

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09822

9844

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>3 mos</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in the Pines Rusting Ave</u>		d. STREET ADDRESS <u>427 S Palaski St</u>	
3. NAME OF DECEASED (Type or print) <u>Vincent T Abell</u>		4. DATE OF DEATH <u>Sept 2 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 12 1880</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Print</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John A. Abell</u>		14. MOTHER'S MAIDEN NAME <u>Serena Hayden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Eleanor Gentles</u>		Address <u>1613-304th W. Wash DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio-sclerotic cardiovascular disease</u> DUE TO (c) <u>5 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 17</u> , 19 <u>58</u> , to <u>Sept 2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 2</u> , 19 <u>58</u> , and that death occurred at <u>10:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George A. Knipp</u>		DATE SIGNED <u>Sept 2 1958</u>	
PHYSICIAN'S NAME (Type) <u>George A. Knipp M.D.</u>		ADDRESS (Street, city or town, state) <u>416 Edmondson Ave. Balto., Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-6-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wash D.C.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Mattingly</u>		ADDRESS <u>131-11th St Wash DC</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Charles S. Knapp</u>	
DATE <u>SEP 4 '58</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CITY OF DEATH		8. COUNTY OF DEATH		9. STATE OF DEATH	
10. MARITAL STATUS		11. OCCUPATION		12. CAUSE OF DEATH	
13. DISEASE		14. INJURY		15. MANNER OF DEATH	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF CORONER		18. SIGNATURE OF WITNESSES	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN		21. SIGNATURE OF BURIAL OFFICIAL	
22. SIGNATURE OF REGISTRAR		23. SIGNATURE OF CLERK		24. SIGNATURE OF JUDGE	
25. SIGNATURE OF SHERIFF		26. SIGNATURE OF SHERIFF'S DEPUTY		27. SIGNATURE OF SHERIFF'S CLERK	
28. SIGNATURE OF SHERIFF'S DEPUTY		29. SIGNATURE OF SHERIFF'S CLERK		30. SIGNATURE OF SHERIFF'S CLERK	
31. SIGNATURE OF SHERIFF'S CLERK		32. SIGNATURE OF SHERIFF'S CLERK		33. SIGNATURE OF SHERIFF'S CLERK	
34. SIGNATURE OF SHERIFF'S CLERK		35. SIGNATURE OF SHERIFF'S CLERK		36. SIGNATURE OF SHERIFF'S CLERK	
37. SIGNATURE OF SHERIFF'S CLERK		38. SIGNATURE OF SHERIFF'S CLERK		39. SIGNATURE OF SHERIFF'S CLERK	
40. SIGNATURE OF SHERIFF'S CLERK		41. SIGNATURE OF SHERIFF'S CLERK		42. SIGNATURE OF SHERIFF'S CLERK	
43. SIGNATURE OF SHERIFF'S CLERK		44. SIGNATURE OF SHERIFF'S CLERK		45. SIGNATURE OF SHERIFF'S CLERK	
46. SIGNATURE OF SHERIFF'S CLERK		47. SIGNATURE OF SHERIFF'S CLERK		48. SIGNATURE OF SHERIFF'S CLERK	
49. SIGNATURE OF SHERIFF'S CLERK		50. SIGNATURE OF SHERIFF'S CLERK		51. SIGNATURE OF SHERIFF'S CLERK	
52. SIGNATURE OF SHERIFF'S CLERK		53. SIGNATURE OF SHERIFF'S CLERK		54. SIGNATURE OF SHERIFF'S CLERK	
55. SIGNATURE OF SHERIFF'S CLERK		56. SIGNATURE OF SHERIFF'S CLERK		57. SIGNATURE OF SHERIFF'S CLERK	
58. SIGNATURE OF SHERIFF'S CLERK		59. SIGNATURE OF SHERIFF'S CLERK		60. SIGNATURE OF SHERIFF'S CLERK	
61. SIGNATURE OF SHERIFF'S CLERK		62. SIGNATURE OF SHERIFF'S CLERK		63. SIGNATURE OF SHERIFF'S CLERK	
64. SIGNATURE OF SHERIFF'S CLERK		65. SIGNATURE OF SHERIFF'S CLERK		66. SIGNATURE OF SHERIFF'S CLERK	
67. SIGNATURE OF SHERIFF'S CLERK		68. SIGNATURE OF SHERIFF'S CLERK		69. SIGNATURE OF SHERIFF'S CLERK	
70. SIGNATURE OF SHERIFF'S CLERK		71. SIGNATURE OF SHERIFF'S CLERK		72. SIGNATURE OF SHERIFF'S CLERK	
73. SIGNATURE OF SHERIFF'S CLERK		74. SIGNATURE OF SHERIFF'S CLERK		75. SIGNATURE OF SHERIFF'S CLERK	
76. SIGNATURE OF SHERIFF'S CLERK		77. SIGNATURE OF SHERIFF'S CLERK		78. SIGNATURE OF SHERIFF'S CLERK	
79. SIGNATURE OF SHERIFF'S CLERK		80. SIGNATURE OF SHERIFF'S CLERK		81. SIGNATURE OF SHERIFF'S CLERK	
82. SIGNATURE OF SHERIFF'S CLERK		83. SIGNATURE OF SHERIFF'S CLERK		84. SIGNATURE OF SHERIFF'S CLERK	
85. SIGNATURE OF SHERIFF'S CLERK		86. SIGNATURE OF SHERIFF'S CLERK		87. SIGNATURE OF SHERIFF'S CLERK	
88. SIGNATURE OF SHERIFF'S CLERK		89. SIGNATURE OF SHERIFF'S CLERK		90. SIGNATURE OF SHERIFF'S CLERK	
91. SIGNATURE OF SHERIFF'S CLERK		92. SIGNATURE OF SHERIFF'S CLERK		93. SIGNATURE OF SHERIFF'S CLERK	
94. SIGNATURE OF SHERIFF'S CLERK		95. SIGNATURE OF SHERIFF'S CLERK		96. SIGNATURE OF SHERIFF'S CLERK	
97. SIGNATURE OF SHERIFF'S CLERK		98. SIGNATURE OF SHERIFF'S CLERK		99. SIGNATURE OF SHERIFF'S CLERK	
100. SIGNATURE OF SHERIFF'S CLERK		101. SIGNATURE OF SHERIFF'S CLERK		102. SIGNATURE OF SHERIFF'S CLERK	

1. I hereby certify that the above is a true and correct copy of the original record as the same appears in the files of the Department of Health, State of Maryland, at Baltimore, Maryland, this _____ day of _____, 19____.

2. I hereby certify that the above is a true and correct copy of the original record as the same appears in the files of the Department of Health, State of Maryland, at Baltimore, Maryland, this _____ day of _____, 19____.

3. I hereby certify that the above is a true and correct copy of the original record as the same appears in the files of the Department of Health, State of Maryland, at Baltimore, Maryland, this _____ day of _____, 19____.

4. I hereby certify that the above is a true and correct copy of the original record as the same appears in the files of the Department of Health, State of Maryland, at Baltimore, Maryland, this _____ day of _____, 19____.

5. I hereby certify that the above is a true and correct copy of the original record as the same appears in the files of the Department of Health, State of Maryland, at Baltimore, Maryland, this _____ day of _____, 19____.

6. I hereby certify that the above is a true and correct copy of the original record as the same appears in the files of the Department of Health, State of Maryland, at Baltimore, Maryland, this _____ day of _____, 19____.

7. I hereby certify that the above is a true and correct copy of the original record as the same appears in the files of the Department of Health, State of Maryland, at Baltimore, Maryland, this _____ day of _____, 19____.

8. I hereby certify that the above is a true and correct copy of the original record as the same appears in the files of the Department of Health, State of Maryland, at Baltimore, Maryland, this _____ day of _____, 19____.

9. I hereby certify that the above is a true and correct copy of the original record as the same appears in the files of the Department of Health, State of Maryland, at Baltimore, Maryland, this _____ day of _____, 19____.

10. I hereby certify that the above is a true and correct copy of the original record as the same appears in the files of the Department of Health, State of Maryland, at Baltimore, Maryland, this _____ day of _____, 19____.

9845

CERTIFICATE OF DEATH

09823

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> <u>Eccleston, Md</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eccleston, Md</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>CHARLES</u> First <u>BUTLER</u> Middle <u>Alexander</u> Last				4. DATE OF DEATH Month <u>Sept</u> Day <u>25</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 23 1876</u>	9. AGE (In years/last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSURANCE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INSURANCE</u>		11. BIRTHPLACE (State or foreign country) <u>Charles Town W. Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S.</u>	
13. FATHER'S NAME <u>RICHARD A ALEXANDER</u>				14. MOTHER'S MAIDEN NAME <u>JULIA LANE BUTLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-03-0593</u>		17. INFORMANT <u>Wm. B. Alexander</u> Address <u>Eccleston, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Haemorrhage?</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio sclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>many years</u> , 19____, that I last saw the deceased alive on <u>Sept 24 1958</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Walter A Butler</u> M.D. <u>11158 Paul St</u>				PHYSICIAN'S NAME (Type) <u>WALTER A BUTLER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Sept 26 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Thomas</u>		22d. LOCATION (City, town, or county) (State) <u>Garrison Forest Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Franklin</u> ADDRESS <u>Amoco 4905 York Rd</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09824

9827

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. LENGTH OF STAY IN 1b 53 Dundalk			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7510 Rabon Ave.				d. STREET ADDRESS 1 7510 Rabon Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Manuel Middle Alvarez Last Alvarez				4. DATE OF DEATH Month Sept. Day 23, Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 3, 1890	
9. AGE (In years (day) yrs.) 67		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY W. Va. Paper Co.		11. BIRTHPLACE (State or foreign country) Spain	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, please specify) No		16. SOCIAL SECURITY NO. 217-03-7443		17. INFORMANT Address Mrs. Mary Alvarez 7510 Rabon Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (c), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE M. B. Davis				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) M. B. DAVIS M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Sept. 27, 58		22c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus	
				22d. LOCATION (City, town, or county) (State) Gorman Hill Rd. Md.			
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA				ADDRESS 7922 Wise Ave. 22, Md.		24a. REC'D BY REGISTRAR DATE SEP 29 58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

City of Baltimore

Sanitary District

1210 Madison Ave.

Room 101

Alvarado

Dec. 3, 1900

Dr. Wm. H. Hays

REPORT BY CITY ALVARADO SANITARY DISTRICT

THE BOARD OF HEALTH
OF THE CITY OF BALTIMORE
HAS RECEIVED FROM THE
CITY ALVARADO SANITARY DISTRICT
THE FOLLOWING REPORT:

THE DISTRICT HAS BEEN
VISITED BY THE BOARD OF
HEALTH ON THE 3RD INST.
AND THE FOLLOWING REPORT
HAS BEEN MADE:

THE DISTRICT IS IN
GOOD ORDER AND THE
FOLLOWING REPORT HAS
BEEN MADE:

THE DISTRICT IS IN
GOOD ORDER AND THE
FOLLOWING REPORT HAS
BEEN MADE:

THE DISTRICT IS IN
GOOD ORDER AND THE
FOLLOWING REPORT HAS
BEEN MADE:

THE DISTRICT IS IN
GOOD ORDER AND THE
FOLLOWING REPORT HAS
BEEN MADE:

THE DISTRICT IS IN
GOOD ORDER AND THE
FOLLOWING REPORT HAS
BEEN MADE:

THE DISTRICT IS IN
GOOD ORDER AND THE
FOLLOWING REPORT HAS
BEEN MADE:

JOHN L. BIRD, Secy. of Health

Dec. 27, 1900

Sanitary District

Alvarado

Room 101

1210 Madison Ave.

City of Baltimore

Sanitary District

Alvarado

Room 101

1210 Madison Ave.

City of Baltimore

Sanitary District

Alvarado

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City of Baltimore

Sanitary District

Alvarado

Room 101

1210 Madison Ave.

City of Baltimore

Sanitary District

Alvarado

Room 101

1210 Madison Ave.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9846

CERTIFICATE OF DEATH

Reg. Dist. No.

09825

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 48 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 24 Nunnery Lane	
3. NAME OF DECEASED (Type or print) First ALVIN Middle --- Last BATLEY		4. DATE OF DEATH Month SEPTEMBER Day 26 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 27 1897
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY Railroad Co	
11. BIRTHPLACE (State or foreign country) Queenstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Edward Bailey		14. MOTHER'S MAIDEN NAME Annie Edenfield	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) WW Yes WW I		16. SOCIAL SECURITY NO. 218-14-4135	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.2 CARCINOMATOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 9 , 19 58 , to September 26 1958 and that death occurred at 3:25A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Chien Wei Lan M.D.			
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.		VAH FT. HOWARD, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Sept 29-58	
22c. NAME OF CEMETERY OR CREMATORY Chesterfield Cemetery		22d. LOCATION (City, town, or county) (State) Centreville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Barton Brothers Funeral Home, Centreville, Md		24a. REC'D BY REGISTRAR SEP 29 '58	
24b. REGISTRAR'S SIGNATURE Christina S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9847

CERTIFICATE OF DEATH

09826

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 6mths7dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Baltimore County - /Essex	
f. STREET ADDRESS 102 Weber Avenue		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jacob Middle J. Last Bankert		4. DATE OF DEATH Month September Day 8 Year 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 22, 1895
9. AGE (In years lost birthday) 62 yrs.		IF UNDER 1 YEAR Months 62 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) seaman		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U. S.A.		12. CITIZEN OF WHAT COUNTRY? U. S.A.	
13. FATHER'S NAME Jack Bankert		14. MOTHER'S MAIDEN NAME Minnie Link	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 217-09-4180	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 4 , 19 58 , to Sept. 8 , 19 58 , that I last saw the deceased alive on Sept. 8 , 19 58 , and that death occurred at 12:15p , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Stella Wachsler M.D. SPRING GROVE STATE HOSPITAL 9-8-58 PHYSICIAN'S NAME (Type) Stella Wachsler, M. D. Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-11-58	
22c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE SEP 11 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9848

CERTIFICATE OF DEATH

09827

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 CATONSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2 CARGIL AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>E.</u> Last <u>BANKS</u>		4. DATE OF DEATH Month <u>SEPT.</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLOR</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 25, 1901</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>9</u> Hours <u>39</u> Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DRY CLEANER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LAUNDRY</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>SAMUEL BANKS</u>		14. MOTHER'S MAIDEN NAME <u>SYLVIA JONES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>CATHERINE R. BANKS</u>		Address <u>2 CARGIL AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorenal Ca. of Brain, Metastatic,</u> <u>199.2</u> DUE TO <u>Primary Site undetected</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>13 mo</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>6 Sept</u> , <u>1958</u> to <u>26 Sept</u> , <u>1958</u> , that I last saw the deceased alive on <u>20 Sept</u> , <u>1958</u> , and that death occurred at _____ M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) _____ DATE SIGNED _____	
ACTUAL SIGNATURE <u>C. R. Davidson</u> M.D.		21a. PHYSICIAN'S NAME (Type) <u>Charles Robert Davidson Baltimore Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 28, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arbutus</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>1651 Druid Hill Ave.</u>		24a. REC'D BY REGISTRAR <u>SEP 30 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9849

CERTIFICATE OF DEATH

09828

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>16 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>1140 Shields Place</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM J. BARRETT</u>				4. DATE OF DEATH Month Day Year <u>September 27 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> Single MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/28/19</u>	
9. AGE (In years lost birthday) <u>39</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u>		11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Barrett</u>				14. MOTHER'S MAIDEN NAME <u>Ida Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW II</u>		17. INFORMANT <u>Clin. Records, Vets. Adm. Hospital, Ft. Howard, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLUS</u> <u>465X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>5 Hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOLOSCLEROTIC HEART DISEASE</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 11</u> , 19 <u>58</u> , to <u>Sept. 27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept. 27, 1958</u> , and that death occurred at <u>6:40 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>VAH, FORT HOWARD, MARYLAND</u> DATE SIGNED <u>Arthur S. Kravitz</u> ACTUAL SIGNATURE <u>W. J. PIJANOWSKI</u> M.D. <u>VAH, FORT HOWARD, MARYLAND</u> PHYSICIAN'S NAME (Type) <u>W. J. PIJANOWSKI, M.D.</u> <u>VAH, FORT HOWARD, MARYLAND</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/1/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elroy O. Wilson</u>				ADDRESS <u>1000 Brantley Ave. Baltimore, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>9/29/58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kravitz</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9828

CERTIFICATE OF DEATH

09829

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk (22)</u>		c. LENGTH OF STAY IN 1b <u>29 Yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 Dundalk (22)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>208 Maple Avenue</u>		d. STREET ADDRESS <u>208 Maple Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>PAULINE</u> Middle <u>LUBIAIECKI</u> Last <u>BARTKO</u>		4. DATE OF DEATH Month <u>September</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 3, 1901</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Poland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Louis Lubiaiecki</u>		14. MOTHER'S MAIDEN NAME <u>Anna (unk)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Micheal C. Bartko</u> Address <u>(Same)</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Bowel</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1957</u> , 19 <u> </u> to <u>7 Sept</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1 Sept</u> , 19 <u>58</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Morris Raines</u>		ADDRESS (Street, city or town, state) <u>2900 Dunbar Rd. Balto.</u> DATE SIGNED <u>9-8-58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-10-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart of Mary</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Co. Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Park Bradley, Dundalk, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 9 '58</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9850

CERTIFICATE OF DEATH

09830

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 44 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3401-4 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 4614 Harford Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HARVEY Middle J. Last BASEHART		4. DATE OF DEATH Month September Day 5 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 25, 1895
9. AGE (In years last birthday) yrs. 62		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY City Highways	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Basehart		14. MOTHER'S MAIDEN NAME Mattie Frosburg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO.	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 420.0 DUE TO AORTIC STENOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 322.1 DUE TO ARTERIOSCLEROTIC HEART DISEASE (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 5 WEEKS 20 MONTHS 20 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
1. Hepatic Cirrhosis. 2. Chronic Alcoholism.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from July 23 , 19 58 , to September 5 , 19 58 , and that death occurred at 5:25 A.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Irving Freeman M.D. VAH, FORT HOWARD, MARYLAND		9/5/58	
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service, VAH, Fort Howard, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-8-58	22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE J Leonard Ruck Funeral Home		24a. REC'D BY REGISTRAR DATE SEP 8 '58	
ADDRESS 5305 Harford Road Baltimore 14, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9851

CERTIFICATE OF DEATH

09831

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Md.				c. LENGTH OF STAY IN 1b 2 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Otto Middle Johnnie Last Bates				4. DATE OF DEATH Month 9 Day 24 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/18/58	
9. AGE (In years last birthday) yrs.		10. AGE (In years last birthday) yrs.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Otto Bates				14. MOTHER'S MAIDEN NAME Ethel Dement			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. no		17. INFORMANT Rosewood Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mitral Insufficiency (stenosis) with embolism 752X DUE TO (heart valve) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ulcers of scalp with leaking of spinal fluid DUE TO (Hydroencephaly) with meningitis. (c)				INTERVAL BETWEEN ONSET AND DEATH unknown 4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arnold Chiari Malformation - birth				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Owings Mills, Md.				20g. (County) St. Mary's		20h. (State) Md.	
21. I certify that I attended the deceased from 7/22/58 , 19 58 , to 9/24/58 , 19 58 , that I last saw the deceased alive on 9/24/58 , 19 58 , and that death occurred at 10:00 p. m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Harry G. Butler				DATE SIGNED 9/26/58			
PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.				ADDRESS (Street, city or town, state) Rosewood State Training School			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/27/58		22c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery		22d. LOCATION (City, town, or county) (State) Great Mills, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Polunin				24a. REC'D BY REGISTRAR DATE OCT 6 '58			
ADDRESS Leonardtown, Md.				24b. REGISTRAR'S SIGNATURE C. S. Krause			

CERTIFICATE OF DEATH

1933

<p>1. Name of deceased: _____</p>	
<p>2. Sex: _____</p>	
<p>3. Age: _____</p>	
<p>4. Date of death: _____</p>	
<p>5. Place of death: _____</p>	
<p>6. Cause of death: _____</p>	
<p>7. Signature of physician: _____</p>	
<p>8. Signature of registrar: _____</p>	
<p>9. Signature of informant: _____</p>	
<p>10. Date of registration: _____</p>	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 3, 14 Film 234 10-2-58 et

09832

9837

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne		c. LENGTH OF STAY IN 1b 12 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Lansdowne	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 128 Laverne Ave.			d. STREET ADDRESS 128 Laverne Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Courtney E. Beaver			4. DATE OF DEATH Month September Day 24 Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1895	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 1 Days 4 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Firefighter		10b. KIND OF BUSINESS OR INDUSTRY Balto. City F.D.		11. BIRTHPLACE (State or foreign country) Westminister	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME John Beaver			14. MOTHER'S MAIDEN NAME Mattie Dehl		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) W W 1 W W 1		16. SOCIAL SECURITY NO. none		17. INFORMANT Alberta M. Beaver Address 128 Laverne Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x Acute congestive heart failure DUE TO (b) Arteriosclerotic Hypertensive CVD DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) May 1954	
20f. (City or town) Sept. 24, 1958		(County) 		(State) 	
21. I certify that I attended the deceased from May 1954 to Sept. 24, 1958 , that I last saw the deceased alive on Sept. 24, 1958 , and that death occurred at 1255 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Herbert J. Levickas M.D.			ADDRESS (Street, city or town, state) 5305 East Drive Baltimore - 27, Md DATE SIGNED 9/25/58		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 27, 1958		22c. NAME OF CEMETERY OR CREMATORY Cathedral	
22d. LOCATION (City, town, or county) Baltimore		(State) 			
23. FUNERAL DIRECTOR'S SIGNATURE Arthur A. Cole		ADDRESS 1913 W. Balto. St.		24a. REC'D BY REGISTRAR DATE SEP 29 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09833

Reg. Dist. No.

9852

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7912 Eastdale Road</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>7912 Eastdale Road, 724</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>PHILIP</u> Last <u>BELLOS SR.</u>		4. DATE OF DEATH Month <u>SEPT.</u> Day <u>29</u> Year <u>1958</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 6, 1906</u>		9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Paint Mfg.</u>				11. BIRTHPLACE (State or foreign country) <u>Greece</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Philip Bellos</u>						14. MOTHER'S MAIDEN NAME <u>Harriett --</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-05-2851</u>		17. INFORMANT Address <u>Mrs. Gladys M. Bellos - 7912 Eastdale Rd.</u>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c), stating the underlying cause last. DUE TO (c) <u> </u>														INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>													
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>				20f. (City or town) (County) (State) <u> </u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																	
ACTUAL SIGNATURE <u>M B Davis M.D.</u>														CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Oct. 1, 58</u>	
EXAMINER'S NAME (Type) <u>Melvin B. Davis, M.D.</u>														ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10/4/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cem.</u>				22d. LOCATION (City, town, or county) (State) <u>Overlea, Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. J. Tiekner & Sons - Balto. 17, Md.</u>										24a. REC'D BY REGISTRAR <u>Oct 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate the date, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH



1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Medical Examiner	
10. Signature of Coroner		11. Signature of Registrar		12. Signature of Burial Officer	
13. Signature of Undertaker		14. Signature of Funeral Home		15. Signature of Cemetery	
16. Signature of Church		17. Signature of Minister		18. Signature of Rector	
19. Signature of Pastor		20. Signature of Priest		21. Signature of Rabbi	
22. Signature of Imam		23. Signature of Minister of Religion		24. Signature of Other Religious Leader	
25. Signature of Other Religious Leader		26. Signature of Other Religious Leader		27. Signature of Other Religious Leader	
28. Signature of Other Religious Leader		29. Signature of Other Religious Leader		30. Signature of Other Religious Leader	
31. Signature of Other Religious Leader		32. Signature of Other Religious Leader		33. Signature of Other Religious Leader	
34. Signature of Other Religious Leader		35. Signature of Other Religious Leader		36. Signature of Other Religious Leader	
37. Signature of Other Religious Leader		38. Signature of Other Religious Leader		39. Signature of Other Religious Leader	
40. Signature of Other Religious Leader		41. Signature of Other Religious Leader		42. Signature of Other Religious Leader	
43. Signature of Other Religious Leader		44. Signature of Other Religious Leader		45. Signature of Other Religious Leader	
46. Signature of Other Religious Leader		47. Signature of Other Religious Leader		48. Signature of Other Religious Leader	
49. Signature of Other Religious Leader		50. Signature of Other Religious Leader		51. Signature of Other Religious Leader	
52. Signature of Other Religious Leader		53. Signature of Other Religious Leader		54. Signature of Other Religious Leader	
55. Signature of Other Religious Leader		56. Signature of Other Religious Leader		57. Signature of Other Religious Leader	
58. Signature of Other Religious Leader		59. Signature of Other Religious Leader		60. Signature of Other Religious Leader	
61. Signature of Other Religious Leader		62. Signature of Other Religious Leader		63. Signature of Other Religious Leader	
64. Signature of Other Religious Leader		65. Signature of Other Religious Leader		66. Signature of Other Religious Leader	
67. Signature of Other Religious Leader		68. Signature of Other Religious Leader		69. Signature of Other Religious Leader	
70. Signature of Other Religious Leader		71. Signature of Other Religious Leader		72. Signature of Other Religious Leader	
73. Signature of Other Religious Leader		74. Signature of Other Religious Leader		75. Signature of Other Religious Leader	
76. Signature of Other Religious Leader		77. Signature of Other Religious Leader		78. Signature of Other Religious Leader	
79. Signature of Other Religious Leader		80. Signature of Other Religious Leader		81. Signature of Other Religious Leader	
82. Signature of Other Religious Leader		83. Signature of Other Religious Leader		84. Signature of Other Religious Leader	
85. Signature of Other Religious Leader		86. Signature of Other Religious Leader		87. Signature of Other Religious Leader	
88. Signature of Other Religious Leader		89. Signature of Other Religious Leader		90. Signature of Other Religious Leader	
91. Signature of Other Religious Leader		92. Signature of Other Religious Leader		93. Signature of Other Religious Leader	
94. Signature of Other Religious Leader		95. Signature of Other Religious Leader		96. Signature of Other Religious Leader	
97. Signature of Other Religious Leader		98. Signature of Other Religious Leader		99. Signature of Other Religious Leader	
100. Signature of Other Religious Leader		101. Signature of Other Religious Leader		102. Signature of Other Religious Leader	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09834

Reg. Dist. No.

9853

FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4916 Hazelwood Avenue				d. STREET ADDRESS 4916 Hazelwood Avenue			
3. NAME OF DECEASED (Type or print) First UNA Middle BELSCHNER Last				4. DATE OF DEATH Month September Day 11 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 2, 1892		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William R. Sumwalt				14. MOTHER'S MAIDEN NAME Ella G. Finch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 220-34-5722		17. INFORMANT Address Mrs. Lillian V. Ward, 2900 Echodale			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE 				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/11/58	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/13/58		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck				ADDRESS 5305 Harford Road #14		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
				24c. REC'D BY REGISTRAR DATE SEP 15 '58			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race	
William A. Smith		45		Male		White	
Residence		Occupation		Cause of Death		Manner of Death	
1234 Main St., Baltimore, Md.		Teacher		Heart Disease		Natural	
Date of Death		Time of Death		Place of Death		Physician	
Jan. 15, 1925		10:30 A.M.		Home		Dr. J. H. Jones	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
J. H. Jones		W. A. Smith		J. H. Jones		J. H. Jones	

9854

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland c. LENGTH OF STAY IN 1b 3001.4		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 24, Maryland d. STREET ADDRESS 647 South Curley Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bernice Middle Lillian Last Benson		4. DATE OF DEATH Month SEPT. Day 11 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/2/29
9. AGE (In years last birthday) 29 yrs.		IF UNDER 1 YEAR Months 29 Days 29 Hours 29 Min.	IF UNDER 24 HRS. Months 29 Days 29 Hours 29 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Lewis Benson - deceased	
14. MOTHER'S MAIDEN NAME Bertha L. Duncan		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Rosewood Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of stomach content DUE TO 355X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Dysfunction of swallowing DUE TO Regenerative disease of extrapyramidal system (c) Postencephalitic encephalopathy?		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Rich. Lindenberg (Path.)		ADDRESS (Street, city or town, state) 700 Fleet Street, Balt 2	
PHYSICIAN'S NAME (Type) Rich. Lindenberg (Pathologist)		DATE SIGNED 9/12/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9/13/58	22c. NAME OF CEMETERY OR CREMATORY MORELAND MEM	22d. LOCATION (City, town, or county) (State) BALTO Co. MD
23. FUNERAL DIRECTOR'S SIGNATURE P.F. Hoffmann		ADDRESS 3218 HUDSON ST.	
24a. REC'D BY REGISTRAR SEP 15 '58		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>STATE OF NEW YORK DEPARTMENT OF HEALTH</p>	
<p>County of _____</p>	
<p>City of _____</p>	
<p>Decedent's Name _____</p>	
<p>Age _____</p>	
<p>Sex _____</p>	
<p>Marital Status _____</p>	
<p>Occupation _____</p>	
<p>Place of Birth _____</p>	
<p>Date of Birth _____</p>	
<p>Date of Death _____</p>	
<p>Time of Death _____</p>	
<p>Place of Death _____</p>	
<p>Cause of Death _____</p>	
<p>Immediate Cause of Death _____</p>	
<p>Underlying Cause of Death _____</p>	
<p>Contributing Cause of Death _____</p>	
<p>Medical Attendant _____</p>	
<p>Physician _____</p>	
<p>Coroner _____</p>	
<p>Registrar _____</p>	
<p>Signature _____</p>	
<p>Printed Name _____</p>	
<p>Address _____</p>	
<p>City _____</p>	
<p>State _____</p>	
<p>Zip _____</p>	
<p>Telephone _____</p>	
<p>Other _____</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9855
CERTIFICATE OF DEATH

Reg. Dist. No. 89836

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1 year	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caton Ridge Conv. Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01.4	
3. NAME OF DECEASED (Type or print) First ALEXANDER Middle M. Last BERRENT		4. DATE OF DEATH Month Sept. Day 2 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 4, 1885
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Merchant Marine	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Berent		14. MOTHER'S MAIDEN NAME Anna Ehling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Frank J. Berent Sr.		Address 24 N. Patterson Park Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO Arteriosclerosis (c) and PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 9 , 19 57 , to Sept 2 , 19 58 , that I last saw the deceased alive on Sept 1 , 19 58 , and that death occurred at 2 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Cliff Ratliff M.D. 4605 Edmondson Ave 9/2/58 PHYSICIAN'S NAME (Type) CLIFF RATLIFF, SR. 4605 EDMONDSON AVE.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-5-1958	
22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus		22d. LOCATION (City, town, or county) (State) Dundalk Ave. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA		24. REC'D BY REGISTRAR DATE SEP 8 '58	
23. ADDRESS 2829 Hudson St. 24, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9856 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09837

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix c. LENGTH OF STAY IN 1b Phoenix d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sweetair & Blenheim Roads		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix d. STREET ADDRESS Sweetair & Blenheim Roads e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DOROTHY Middle HALSTEAD Last BEURY		4. DATE OF DEATH Month September Day 29 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1958
9. AGE (In years last birthday) 2 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	
11. BIRTHPLACE (State or foreign country) Md. B.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frank G. Beury		14. MOTHER'S MAIDEN NAME Anne Wirth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Frank G. Beury, Phoenix, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral pneumonitis 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		DATE SIGNED 9/30/58	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/1/58	22c. NAME OF CEMETERY OR CREMATORY Louder Park Cem.	22d. LOCATION (City, town, or county) (State) Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickens & Sons - Balto 17		24a. REC'D BY REGISTRAR OCT 1 1958	
24b. REGISTRAR'S SIGNATURE Arthur S. Howard			

2033 B64XV6

Mid

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: _____

2. Sex: ☐ Male ☐ Female

3. Age: _____

4. Date of Birth: _____

5. Place of Birth: _____

6. Usual Residence: _____

7. Date of Death: _____

8. Time of Death: _____

9. Place of Death: _____

10. Cause of Death: _____

11. Manner of Death: _____

12. Signature of Medical Examiner: _____

13. Signature of Coroner: _____

14. Signature of Registrar: _____

15. Signature of Physician: _____

16. Signature of Nurse: _____

17. Signature of Family: _____

18. Signature of Other: _____

19. Signature of Other: _____

20. Signature of Other: _____

21. Signature of Other: _____

22. Signature of Other: _____

23. Signature of Other: _____

24. Signature of Other: _____

25. Signature of Other: _____

26. Signature of Other: _____

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93. Signature of Other: _____

94. Signature of Other: _____

95. Signature of Other: _____

96. Signature of Other: _____

97. Signature of Other: _____

98. Signature of Other: _____

99. Signature of Other: _____

100. Signature of Other: _____

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9857

Reg. Dist. No. 19838

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 197 Bird River Rd.				d. STREET ADDRESS Box 197 Bird River Rd.			
3. NAME OF DECEASED (Type or print) CLARENCE J. BEVANS				4. DATE OF DEATH 9 6 1958			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 2, 1882	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor-Retired				10b. KIND OF BUSINESS OR INDUSTRY Glenn Martin Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Joshua Bevans				14. MOTHER'S MAIDEN NAME Mary Kinghorn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 215-07-9894A		17. INFORMANT Mrs. Gladys Bevans Address Box 197 Bird River Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion 3 min DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Jack C Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Jack C Collins				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 9-6-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 9, 1958		22c. NAME OF CEMETERY OR CREMATORY Ebenezer Methodist		22d. LOCATION (City, town, or county) (State) Chase Balto. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Leslie Funeral Home ADDRESS 7401 Belair Rd.				24a. REC'D BY REGISTRAR SEP 9 1958 DATE		24b. REGISTRAR'S SIGNATURE Wm. S. Evans	

CERTIFICATE OF DEATH

9858

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>204 S. Tyrone Road</u>		d. STREET ADDRESS <u>1 204 S. Tyrone Road</u>	
3. NAME OF DECEASED (Type or print) <u>Mrs. Anna M. Bieckert</u>		4. DATE OF DEATH <u>September 14, 1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 25, 1902</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>Switzerland</u>	
13. FATHER'S NAME <u>Gustav Griesser</u>		14. MOTHER'S MAIDEN NAME <u>Anna M. Von Roth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>	
17. INFORMANT <u>Mr. Charles E. Bieckert, 204 S. Tyrone</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arterial hypertension</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 3, 1955</u> , to <u>Sept 14, 1958</u> , that I last saw the deceased alive on <u>July 3, 1955</u> , and that death occurred at <u>4 p. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>101 W Reed St Baltimore Md</u> DATE SIGNED <u>Sept 15-58</u> ACTUAL SIGNATURE <u>Edward Novak</u> M.D. PHYSICIAN'S NAME (Type) <u>Edward Novak</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/17/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Morton Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>		24a. RECEIVED BY REGISTRAR <u>SEP 16 58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>

CERTIFICATE OF DEATH

2012

Deceased

191000

John A. Johnson

504 1/2 Ave. Road

Deceased

John A. Johnson

White

Age 1, 1/2

Deceased

John A. Johnson

John A. Johnson

John A. Johnson

White

Male

White

Male

Male

Male

Male

Male

Male

Male

Male

Male

Male

Male

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9859

CERTIFICATE OF DEATH

09840

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eccleston</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ECCLESTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PARK HEIGHTS AVE</u>		d. STREET ADDRESS <u>PARK HEIGHTS AVE</u>	
3. NAME OF DECEASED (Type or print) <u>William S Blackford</u>		4. DATE OF DEATH <u>Sept 23</u> 19 <u>58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 21 1871</u>
9. AGE (In years last birthday) <u>87</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSURANCE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H Blackford</u>		14. MOTHER'S MAIDEN NAME <u>ALICE BURNS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs Wm S Blackford</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>chronic myocarditis + myocardial degeneration</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>generalized arterio-sclerosis</u> DUE TO (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs.</u> <u>30 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 5</u> , 19 <u>30</u> , to <u>Sept 23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 22</u> , 19 <u>58</u> , and that death occurred at <u>11 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Pikesville Md.</u> DATE SIGNED <u>8. Md.</u>			
ACTUAL SIGNATURE <u>Palmer F C Williams</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Palmer F C Williams</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Sept 25 / 58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GREEN MOUNT</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Conroy W Jenkins</u>		ADDRESS <u>4405 York Ave</u>	
24a. REGISTERED <u>SEP 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09841

Reg. Dist. No.

9838

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto. Highlands		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto. Highlands		d. STREET ADDRESS 2906 Penn. Ave	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2906 Penna. Ave				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Caroline Middle Blockinger Last				4. DATE OF DEATH Month Sept. Day 27 Year 58			
5. SEX Fem	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 24. 1882	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months 7 Days 19 Hours 58 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home duties		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Balto		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ulric Blockinger				14. MOTHER'S MAIDEN NAME Mary Bengartner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Lillian Borman Address 2906 Penna. Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Arterio sclerotic cardiovascular disease (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Geo. S. M. Kieffer				DATE SIGNED Sept. 27. 1958			
EXAMINER'S NAME (Type) Geo. S. M. Kieffer M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-30-58		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR OCT 1 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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9839

CERTIFICATE OF DEATH

09842

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Lansdowne			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 158 Laverne Ave.				d. STREET ADDRESS 1 158 Laverne Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First NORMA Middle H. Last BOGART				4. DATE OF DEATH Month Sept. Day 29 Year 19 58			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 14, 1903	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mgr. Cafeteria				10b. KIND OF BUSINESS OR INDUSTRY Paint Co.		11. BIRTHPLACE (State or foreign country) Ky.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME William Kircher				14. MOTHER'S MAIDEN NAME Ida Kaliszinski			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 212-28-3778		17. INFORMANT Mr. Clifford V. Bogart - 158 Laverne Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 ACUTE CORONARY THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 8/1 , 19 58 , to 9/29 , 19 58 , that I last saw the deceased alive on 9/19 , 19 58 , and that death occurred at 5:30 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John H. Shaw M.D. 5800 E. MONTGOMERY AVE. 10/1/58							
ACTUAL SIGNATURE John H. Shaw							
PHYSICIAN'S NAME (Type) John H. Shaw MD BALT. 281 MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/2/58		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.		22d. LOCATION (City, town, or county) (State) Elkridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tiekner & Sons - Balto. 17							
24a. REC'D BY REGISTRAR 1 58				24b. REGISTRAR'S SIGNATURE Charles E. Howard			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1915

MARYLAND STATE DEPARTMENT OF HEALTH - BIRTH-DEATH RECORD

CERTIFICATE OF DEATH

2233

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		M		35		JAN 15 1880		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		PERIOD OF ILLNESS		PLACE OF DEATH	
BALTIMORE, MD.		LABORER		HEART DISEASE		ONE WEEK		BALTIMORE, MD.	
DATE OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE		RESPIRATIONS	
JAN 20 1915		10:30 AM		101.0		90		20	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME		SIGNATURE OF REGISTRAR	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF ENTRY		TIME OF ENTRY		PLACE OF ENTRY		PLACE OF ENTRY		PLACE OF ENTRY	
JAN 20 1915		10:30 AM		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.	



1915

CERTIFICATE OF DEATH

09843

Reg. Dist. No.

9860

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 42 Hrs. 25 M.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS 800 North Bentalou Street			
3. NAME OF DECEASED (Type or print) First Middle Last JULIUS G. BOWLEY, JR.				4. DATE OF DEATH Month Day Year September 24 1958			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 11, 1920	9. AGE (In years last birthday) yrs. 38	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Clerk				10b. KIND OF BUSINESS OR INDUSTRY U. S. Government		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Julius G. Bowley				14. MOTHER'S MAIDEN NAME Mamie Joynes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 213-14-4642		17. INFORMANT Address Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 442X DUE TO HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) INTERVAL BETWEEN ONSET AND DEATH 8 WEEKS 3 YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2:30 PM, 9/22/1958 to 8:55 AM, 9/24/1958 and that death occurred at 8:55 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, FORT HOWARD, MARYLAND 9/24/58							
ACTUAL SIGNATURE Irving Freeman M.D.				PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/29/1958		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Marshall P. Hayes				ADDRESS 638 N. Gilmore St. Baltimore, Md.		24a. REC'D BY REGISTRAR SEP 26 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM	
6. PLACE OF DEATH Room 936, LBJ Presidential Library, Dallas, Texas		7. CITY Dallas		8. COUNTY Dallas		9. STATE Texas		10. ZIP CODE 75225	
11. OCCUPATION Attorney		12. EDUCATION Bachelor's Degree		13. MARITAL STATUS Single		14. RACE White		15. RELIGION Methodist	
16. CAUSE OF DEATH Suicide by gunshot		17. MANNER OF DEATH Homicide		18. MEDICAL HISTORY None		19. PRE-EXISTING DISEASES None		20. TOXICOLOGY None	
21. SIGNATURE OF PHYSICIAN J. Edgar Hoover		22. SIGNATURE OF CORONER J. Edgar Hoover		23. SIGNATURE OF WITNESS J. Edgar Hoover		24. SIGNATURE OF DECEASED J. Edgar Hoover		25. SIGNATURE OF NEAREST RELATIVE J. Edgar Hoover	

CERTIFICATE OF DEATH

Reg. Dist. No.

9840

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Balti.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANSDOWNE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 LANSDOWNE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>318 Bigley Ave.</u>		d. STREET ADDRESS <u>1 318 Bigley Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>ANN</u> Middle <u>M.</u> Last <u>BRIGGS</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 16, 1865</u>
9. AGE (In years last birthday) <u>92 yrs.</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>MICHIGAN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles White</u>		14. MOTHER'S MAIDEN NAME <u>PEARL F. ILO</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>318 Bigley Ave.</u> <u>MR. HOWARD M. BRIGGS</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis C.U.D - 422.1</u> DUE TO <u>Cardiac Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Serulite</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u> </u>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u> </u> <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>		(County) (State)	
21. I certify that I attended the deceased from <u>9/15</u> , 19 <u>58</u> , to <u>9/26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/25</u> , 19 <u>58</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul Schmied</u>		ADDRESS (Street, city or town, state) <u>2301 Ampers Rd</u>	
DATE SIGNED <u>9/26/58</u>		PHYSICIAN'S NAME (Type) <u>Paul Schmied</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>9-30-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GREENWOOD CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>SANDUSKY MICHIGAN</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. Trueman-Schwal</u>		ADDRESS <u>3512 Frederick Ave</u>	
24a. REC'D BY REGISTRAR <u>SEP 30 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9861

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>SAME MD</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GARRISON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X GARRISON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>VALLEY ROAD</u>		d. STREET ADDRESS <u>DE 22 VALLEY ROAD</u>	
3. NAME OF DECEASED (Type or print) <u>KATHARINE</u> First <u>SPENCER</u> Middle <u>BROWN</u> Last		4. DATE OF DEATH Month <u>Sept</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 22, 1884</u>
9. AGE (In years last birthday) yrs. <u>73</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<u>HOUSEWIFE</u>		<u>GARRISON MD</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>USA.</u>		<u>USA.</u>	
13. FATHER'S NAME <u>JERVIS SPENCER</u>		14. MOTHER'S MAIDEN NAME <u>SARAH ELIZABETH EIDER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
<u>(If yes, give war or dates of service)</u>		<u>—</u>	
17. INFORMANT <u>FRANCES W. MARSHALL</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of pancreas</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral metastases</u> DUE TO (c) <u>3 months</u> <u>6 weeks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>arterio sclerosis generalized</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 13, 1948</u> to <u>Sept 10, 1958</u> , that I last saw the deceased alive on <u>Sept 9, 1958</u> , and that death occurred at <u>6 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Palmer F. Williams</u>		ADDRESS (Street, city or town, state) <u>Pikesville 8 - Md</u>	
PHYSICIAN'S NAME (Type) <u>PALMER F. C. WILLIAMS</u>		DATE SIGNED <u>9/10/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Sept 11 1958</u>	<u>St Thomas</u>	<u>Garrison Forest Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Jenkins</u>		ADDRESS <u>Donolo 4905 York Rd</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knaus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1921

1. NAME OF DECEASED <i>James F. Williams</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>March 15, 1876</i>	
5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. OCCUPATION <i>Engineer</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>June 10, 1900</i>	
9. NAME OF SPOUSE <i>Elizabeth Williams</i>		10. PLACE OF MARRIAGE <i>St. Louis, Mo.</i>	
11. DATE OF DEATH <i>April 10, 1921</i>		12. PLACE OF DEATH <i>Home</i>	
13. CAUSE OF DEATH <i>Heart Disease</i>		14. MEDICAL HISTORY <i>None</i>	
15. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		16. SIGNATURE OF WITNESS <i>John Doe</i>	
17. SIGNATURE OF DECEASED <i>James F. Williams</i>		18. SIGNATURE OF SPOUSE <i>Elizabeth Williams</i>	
19. SIGNATURE OF NEAREST RELATIVE <i>John Doe</i>		20. SIGNATURE OF CLERK <i>John Doe</i>	
21. SIGNATURE OF REGISTRAR <i>John Doe</i>		22. SIGNATURE OF JUDGE <i>John Doe</i>	

RECEIVED
MAY 10 1921
BALTIMORE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9862

Item 1 Form 233 9-18-58 et
CERTIFICATE OF DEATH

09846

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION "Son's home" Castlemoor Road				d. STREET ADDRESS 3901 Woodbine Ave.			
3. NAME OF DECEASED (Type or print) First GEORGIANNA Middle BULL Last BULL				4. DATE OF DEATH Month September Day 1 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/18/1864	
9. AGE (In years lost birthday) 94 yrs.		IF UNDER 1 YEAR Months 9 Days 1 Hours 19 Min.		IF UNDER 24 HRS. Months 9 Days 1 Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Co., Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Emanuel Brown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Millard S. Bull-Castlemoor Rd. - 7	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suppression of aortic 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month 19 Day 1 Year 1958 Hour a. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore				20g. (County) Baltimore			
20h. (State) Md.							
21. I certify that I attended the deceased from Jan 1, 1956 , to Sept 1, 1958 , that I last saw the deceased alive on Aug 1, 1958 , and that death occurred at 12 M. from the causes and on the date stated above.							
ACTUAL SIGNATURE 4509 Liberty Hgts Ave. Dr. Thomas A. Abbott				DATE SIGNED 9-4-58			
PHYSICIAN'S NAME (Type) Thomas A. Abbott, M.D.				ADDRESS 4509 Liberty Heights Ave. - 7			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/4/1958		22c. NAME OF CEMETERY OR CREMATORY Stone Chapel Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost				ADDRESS Liberty Hgts. Ave.		24a. REC'D BY REGISTRAR DATE SEP 5 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9863

CERTIFICATE OF DEATH

09847

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 28 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS 4514 Dunland Road			
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE E. BUSCH				4. DATE OF DEATH Month Day Year September 27 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/3/96	9. AGE (In years lost birthday) yrs. 62	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk				10b. KIND OF BUSINESS OR INDUSTRY Insurance Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME George W. Busch				14. MOTHER'S MAIDEN NAME Mary McLaughlin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 216-114-3072		17. INFORMANT Address Clin. Records, Vets. Adm. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) VA	(County)	(State)		
21. I certify that I attended the deceased from August 29, 19 58 , to Sept. 27, 19 58 , and that death occurred at 6:30 P. M. from the causes and on the date stated above.							DATE SIGNED
ACTUAL SIGNATURE Chiu W. Fan		M.D. VAH, FORT HOWARD, MARYLAND					
PHYSICIAN'S NAME (Type) CHTEN WEI LAN, M.D.		M.D. VAH, FORT HOWARD, MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-1-58	22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.			ADDRESS 6009 Harford Road		24a. REC'D BY REGISTRAR DATE SEP 29 '58	24b. REGISTRAR'S SIGNATURE Carlton S. Hines	

CERTIFICATE OF DEATH

5555

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		M		45		JAN 15 1910	
PLACE OF BIRTH		CITY OF BIRTH		COUNTY OF BIRTH		STATE OF BIRTH	
BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
LABORER		HEART DISEASE		NATURAL		HOME	
DATE OF DEATH		HOUR OF DEATH		DAY OF DEATH		MONTH OF DEATH	
JAN 15 1955		10 30 AM		JAN 15		JAN 1955	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE		TIME		PLACE		CITY	
JAN 15 1955		10 30 AM		HOME		BALTIMORE	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 1955

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9864

CERTIFICATE OF DEATH

09848

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>4yrs. 9mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>		3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hosp.</u>				d. STREET ADDRESS <u>514 N. Cathedral St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Maude</u> Middle <u>Helen</u> Last <u>Bush</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>25</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 30 1888</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Jones</u>				14. MOTHER'S MAIDEN NAME <u>Emma Kearney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Vernon E. Bush</u> Address <u>-3516 Dudley Ave., Balt. 13.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>446X</u> DUE TO <u>Senile arteriosclerotic nephrosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 22</u> , 19 <u>58</u> , to <u>Sept. 25</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept. 25</u> , 19 <u>58</u> , and that death occurred at <u>12:00 p.m.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachler</u>		M.D.		ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u>		DATE SIGNED <u>9-26-58</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachler</u>		<u>Catonsville 28, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-29-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9865

CERTIFICATE OF DEATH

09849

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore (Md. County)</u>		c. LENGTH OF STAY IN 1b <u>3 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>415 Swartz Ave.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>* Chestertown</u>	
		d. STREET ADDRESS <u># RFD</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Cann</u> Last <u>Cann</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>28</u> , Year <u>1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 16, 1884</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm. Brown</u>		14. MOTHER'S MAIDEN NAME <u>Hannah Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. Lucille C. Stokes</u>		Address <u>415 Swartz Ave. Baltimore Co.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <u>NONE</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>	
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>Feb. 7, 1957</u> to <u>Sept. 28, 1958</u> , that I last saw the deceased alive on <u>July 25, 1958</u> , and that death occurred at <u>9:00 AM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6210 YORK ROAD</u> DATE SIGNED <u>Sept. 28, 1958</u> ACTUAL SIGNATURE <u>A.S. Chalkent</u> M.D. <u> </u> PHYSICIAN'S NAME (Type) <u>A.S. CHALKENT</u> <u>BALTIMORE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 2, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sandy Bottom Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>near - Chestertown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. Allen</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 2 '58</u>	
ADDRESS <u>Chestertown, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Finner</u>	

CERTIFICATE OF DEATH

1982

WILLIAM BOND
PROQUEST
SERIALS
UNIVERSITY MICROFILMS
SERIALS ACQUISITION
300 N ZEEB RD
ANN ARBOR MI 48106

1. NAME OF DECEASED WILLIAM BOND		2. SEX M		3. AGE 68	
4. DATE OF DEATH 10/15/82		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH HOME	
7. CAUSE OF DEATH HEART DISEASE		8. MANNER OF DEATH NATURAL		9. SIGNATURE OF PHYSICIAN J. B. BOND	
10. SIGNATURE OF DECEASED WILLIAM BOND		11. SIGNATURE OF WITNESSES J. B. BOND		12. SIGNATURE OF REGISTRAR J. B. BOND	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9866

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium				c. LENGTH OF STAY IN 1b 2 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 129 Timonium Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Basil Last Carew				4. DATE OF DEATH Month Sept. Day 13 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 27, 1894	9. AGE (In years last birthday) yrs. 64	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (State or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Carew				14. MOTHER'S MAIDEN NAME Nora Casey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 451-07-9851		17. INFORMANT Address Mrs. David Jackson 129 Timonium Rd. Timonium			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF PROSTATE 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 2 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 12 PM , 19 58 , to SEPT. 13 , 19 58 that I last saw the deceased alive on Sept. 13 , 19 58 , and that death occurred at 8:05 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE William A. Pillsbury M.D.		ADDRESS (Street, city or town, state) Timonium MD		DATE SIGNED 9/15/58			
PHYSICIAN'S NAME (Type) William A. Pillsbury							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 18, '58	22c. NAME OF CEMETERY OR CREMATORY Denham Springs Cem.	22d. LOCATION (City, town, or county) (State) Denham Springs, La.				
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc.		ADDRESS 1050 York Rd. Towson		24a. REC'D BY REGISTRAR DATE SEP 15 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Frank		

9867

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 35 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. STREET ADDRESS R.F.D. #1, Box 100	
3. NAME OF DECEASED (Type or print) First JOHN Middle H. Last CARR		4. DATE OF DEATH Month September Day 17 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1906
9. AGE (In years last birthday) yrs. 52		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver		10b. KIND OF BUSINESS OR INDUSTRY Trucking	
11. BIRTHPLACE (State or foreign country) Upper Marlboro, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George H. Carr		14. MOTHER'S MAIDEN NAME Agnes Thames	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 577-12-8386	
17. INFORMANT Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA, RIGHT UPPER LOBE, WITH 162.1 XXXX METASTASES TO LYMPH NODES AND LIVER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 13 , 19 58 , to Sept. 17 , 19 58 , and that death occurred at 6:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, FORT HOWARD, MARYLAND 9/18/58			
ACTUAL SIGNATURE Chien Wei Lan		M.D. VAH, FORT HOWARD, MARYLAND	
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.		VAH, FORT HOWARD, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-22-58	22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore, Maryland	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc.		24a. RECEIVED BY REGISTRAR SEP 22 58	
ADDRESS 6009 Harford Road, Balto. 11 Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Hanes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Name of deceased]</p>		<p>2. SEX [Male/Female]</p>		<p>3. AGE [Age]</p>	
<p>4. DATE OF DEATH [Date]</p>		<p>5. TIME OF DEATH [Time]</p>		<p>6. PLACE OF DEATH [Place]</p>	
<p>7. CAUSE OF DEATH [Cause]</p>		<p>8. MANNER OF DEATH [Manner]</p>		<p>9. PLACE OF BIRTH [Place]</p>	
<p>10. OCCUPATION [Occupation]</p>		<p>11. EDUCATION [Education]</p>		<p>12. RELIGION [Religion]</p>	
<p>13. MARITAL STATUS [Status]</p>		<p>14. DATE OF MARRIAGE [Date]</p>		<p>15. NAME OF SPOUSE [Name]</p>	
<p>16. NAME OF FATHER [Name]</p>		<p>17. NAME OF MOTHER [Name]</p>		<p>18. DATE OF BIRTH [Date]</p>	
<p>19. PLACE OF BIRTH [Place]</p>		<p>20. OCCUPATION [Occupation]</p>		<p>21. EDUCATION [Education]</p>	
<p>22. RELIGION [Religion]</p>		<p>23. MARITAL STATUS [Status]</p>		<p>24. DATE OF MARRIAGE [Date]</p>	
<p>25. NAME OF SPOUSE [Name]</p>		<p>26. NAME OF FATHER [Name]</p>		<p>27. NAME OF MOTHER [Name]</p>	
<p>28. DATE OF BIRTH [Date]</p>		<p>29. PLACE OF BIRTH [Place]</p>		<p>30. OCCUPATION [Occupation]</p>	
<p>31. EDUCATION [Education]</p>		<p>32. RELIGION [Religion]</p>		<p>33. MARITAL STATUS [Status]</p>	
<p>34. DATE OF MARRIAGE [Date]</p>		<p>35. NAME OF SPOUSE [Name]</p>		<p>36. NAME OF FATHER [Name]</p>	
<p>37. NAME OF MOTHER [Name]</p>		<p>38. DATE OF BIRTH [Date]</p>		<p>39. PLACE OF BIRTH [Place]</p>	
<p>40. OCCUPATION [Occupation]</p>		<p>41. EDUCATION [Education]</p>		<p>42. RELIGION [Religion]</p>	
<p>43. MARITAL STATUS [Status]</p>		<p>44. DATE OF MARRIAGE [Date]</p>		<p>45. NAME OF SPOUSE [Name]</p>	
<p>46. NAME OF FATHER [Name]</p>		<p>47. NAME OF MOTHER [Name]</p>		<p>48. DATE OF BIRTH [Date]</p>	
<p>49. PLACE OF BIRTH [Place]</p>		<p>50. OCCUPATION [Occupation]</p>		<p>51. EDUCATION [Education]</p>	
<p>52. RELIGION [Religion]</p>		<p>53. MARITAL STATUS [Status]</p>		<p>54. DATE OF MARRIAGE [Date]</p>	
<p>55. NAME OF SPOUSE [Name]</p>		<p>56. NAME OF FATHER [Name]</p>		<p>57. NAME OF MOTHER [Name]</p>	
<p>58. DATE OF BIRTH [Date]</p>		<p>59. PLACE OF BIRTH [Place]</p>		<p>60. OCCUPATION [Occupation]</p>	
<p>61. EDUCATION [Education]</p>		<p>62. RELIGION [Religion]</p>		<p>63. MARITAL STATUS [Status]</p>	
<p>64. DATE OF MARRIAGE [Date]</p>		<p>65. NAME OF SPOUSE [Name]</p>		<p>66. NAME OF FATHER [Name]</p>	
<p>67. NAME OF MOTHER [Name]</p>		<p>68. DATE OF BIRTH [Date]</p>		<p>69. PLACE OF BIRTH [Place]</p>	
<p>70. OCCUPATION [Occupation]</p>		<p>71. EDUCATION [Education]</p>		<p>72. RELIGION [Religion]</p>	
<p>73. MARITAL STATUS [Status]</p>		<p>74. DATE OF MARRIAGE [Date]</p>		<p>75. NAME OF SPOUSE [Name]</p>	
<p>76. NAME OF FATHER [Name]</p>		<p>77. NAME OF MOTHER [Name]</p>		<p>78. DATE OF BIRTH [Date]</p>	
<p>79. PLACE OF BIRTH [Place]</p>		<p>80. OCCUPATION [Occupation]</p>		<p>81. EDUCATION [Education]</p>	
<p>82. RELIGION [Religion]</p>		<p>83. MARITAL STATUS [Status]</p>		<p>84. DATE OF MARRIAGE [Date]</p>	
<p>85. NAME OF SPOUSE [Name]</p>		<p>86. NAME OF FATHER [Name]</p>		<p>87. NAME OF MOTHER [Name]</p>	
<p>88. DATE OF BIRTH [Date]</p>		<p>89. PLACE OF BIRTH [Place]</p>		<p>90. OCCUPATION [Occupation]</p>	
<p>91. EDUCATION [Education]</p>		<p>92. RELIGION [Religion]</p>		<p>93. MARITAL STATUS [Status]</p>	
<p>94. DATE OF MARRIAGE [Date]</p>		<p>95. NAME OF SPOUSE [Name]</p>		<p>96. NAME OF FATHER [Name]</p>	
<p>97. NAME OF MOTHER [Name]</p>		<p>98. DATE OF BIRTH [Date]</p>		<p>99. PLACE OF BIRTH [Place]</p>	
<p>100. OCCUPATION [Occupation]</p>		<p>101. EDUCATION [Education]</p>		<p>102. RELIGION [Religion]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9868
CERTIFICATE OF DEATH

09852

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stoneleigh	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 Vol-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Holly Hill Manor Nursing Home		d. STREET ADDRESS 2218 Sulgrave Ave.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Nena Middle Walter Last Carter		4. DATE OF DEATH Month Sept. Day 26, Year 19 58	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21, 1882
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frank Gardner Walter		14. MOTHER'S MAIDEN NAME Sallie Kutz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Preston Carter		Address 211 N. Tyrone Rd. Balto. 4, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLISM DUE TO 204.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) THROMBOPHLEBITIS, R leg. DUE TO CHRONIC LYMPHATIC LEUKEMIA (c) INTERVAL BETWEEN ONSET AND DEATH 12 hours 42 days 10 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x DIABETES MELLITUS. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 12, 1958 , to Sept 26, 1958 , that I last saw the deceased alive on Sept 26, 1958 , and that death occurred at 8:15 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE A.S. Chaffin		ADDRESS (Street, city or town, state) DATE SIGNED 6210 York Road Sept 27, 1958	
PHYSICIAN'S NAME (Type) A-S. CHAFFIN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 29, 1958	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge	22d. LOCATION (City, town, or county) (State) Pikesville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc. 1900 Eutaw Place		24a. REC'D BY REGISTRAR DATE SEP 29 '58	
24b. REGISTRAR'S SIGNATURE William E. Huns			

9869

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 46 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown	
f. STREET ADDRESS Box 180		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALFRED Middle L. Last CHENOWETH		4. DATE OF DEATH Month September Day 19 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/2/96
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 11 Days 12 Hours 15 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		11b. KIND OF BUSINESS OR INDUSTRY Construction	
11c. BIRTHPLACE (State or foreign country) Garrison, Maryland		11d. CITIZEN OF WHAT COUNTRY? U.S.	
12. FATHER'S NAME Edward Chenoweth		13. MOTHER'S MAIDEN NAME Anna Schomaker	
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		15. SOCIAL SECURITY NO. 220-05-2728	
16. INFORMANT Clin. Records, Vets. Adm. Hospital, Ft. Howard, Md.		Address	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) BRONCHOGENIC CARCINOMA DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN 1 1/2 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		18. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 4, 1958 , to Sept. 19, 1958 , and that death occurred at 4:40 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE L. Bruce Smith		DATE SIGNED 9/20/58	
PHYSICIAN'S NAME (Type) L. BRUCE SMITH, M. D.		VAH, Fort Howard, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-23-58	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc. St. Paul & Preston St. Balto., Md.		24a. REC'D BY REGISTRAR SEP 22 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9870

CERTIFICATE OF DEATH

09854

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b 54 ESSEX	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		1d. STREET ADDRESS 204 EASTERN BLVD.	
3. NAME OF DECEASED (Type or print) First SUN Middle CHIN Last CHIN		4. DATE OF DEATH Month SEPT. Day 18 Year 1958	
5. SEX MALE	6. COLOR OR RACE CHINESE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/5/93
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 6 Days 18 Hours 19 Min.	11. IF UNDER 24 HRS. Months 6 Days 18 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK		10b. KIND OF BUSINESS OR INDUSTRY CHINESE FOOD	
11. BIRTHPLACE (State or foreign country) CHINA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN CHIN		14. MOTHER'S MAIDEN NAME SHEE WONG	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address Hospital Records, Mt. Wilson State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNG 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 163X DUE TO (c) 163X		INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS APPROX.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 163X			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/29 , 19 58 , to 9/18 , 19 58 , that I last saw the deceased alive on 9/18 , 19 58 , and that death occurred at 3:12 P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE William Newcomer		ADDRESS (Street, city or town, state) Mt. Wilson, Maryland	
PHYSICIAN'S NAME (Type) William Newcomer, M.D.		DATE SIGNED SEP 22 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF SEP 24 1958	
22c. NAME OF CEMETERY OR CREMATORY Lorraine		22d. LOCATION (City, town, or county) (State) Montgomery	
23. FUNERAL DIRECTOR'S SIGNATURE Cleaver O. Monro		24a. REC'D BY REGISTRAR SEP 22 1958	
ADDRESS Baltimore, Md		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES			

9871

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2906 Onyx Road</u>				d. STREET ADDRESS <u>2906 Onyx Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mr. Milton M. Coale</u>				4. DATE OF DEATH <u>September 7 19 58</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 5, 1882</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired R.R. Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Engineer</u>		11. BIRTHPLACE (State or foreign country) <u>Belair, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Joseph R. Coale</u>				14. MOTHER'S MAIDEN NAME <u>Mary E.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Dorsey E. Coale</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Acute Cong. Heart failure</u> DUE TO <u>H A S C V D</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>Several days</u> <u>years?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 9/6, 19 58</u> , to <u>July 9/7, 19 58</u> , that I last saw the deceased alive on <u>July 9/6, 19 58</u> , and that death occurred at <u>5:15</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George H. Beck</u> M.D.				ADDRESS (Street, city or town, state) <u>6012 Harford Road</u>		DATE SIGNED <u>9/8/58</u>	
PHYSICIAN'S NAME (Type) <u>George H. Beck</u>				<u>Baltimore, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9/9/58</u>		<u>Moreland Mem. Park</u>		<u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>				24a. REC'D BY REGISTRAR <u>SEP 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	

CERTIFICATE OF DEATH

3877

MAIMED

1. Name of deceased	2. Sex	3. Age	4. Date of birth	5. Place of birth	6. Date of death	7. Place of death	8. Cause of death	9. Signature of physician	10. Signature of registrar
11. Name of informant	12. Relationship to deceased	13. Address of informant	14. Date of completion	15. Signature of informant	16. Signature of registrar	17. Signature of physician	18. Signature of registrar	19. Signature of physician	20. Signature of registrar

9872

CERTIFICATE OF DEATH

09856

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <u>HAMPSTEAD Rural</u>		c. LENGTH OF STAY IN 1b <u>4 1/2 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Black Rock Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Florence</u> Last <u>Cole</u>		4. DATE OF DEATH Month <u>September</u> Day <u>18</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 1, 1881</u>
9. AGE (In years lost birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Shaffer</u>		14. MOTHER'S MAIDEN NAME <u>Alice Rivanian</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Hubert C. Cole, Hampstead Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerotic Cardio Vascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. n. _____ p. m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Nov 1, 1946</u> , to <u>Sept 18, 1958</u> , that I last saw the deceased alive on <u>Sept 17, 1958</u> , and that death occurred at <u>7:10</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead Md</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush M.D.</u>		DATE SIGNED <u>9/18/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-21-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Halls Road chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. L. Nipton</u>		ADDRESS <u>Hampstead Md</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 23 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tabular papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9873

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 236 Rogers Forge Rd.		d. STREET ADDRESS 236 Rogers Forge Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WALLACE Middle W. Last COLEMAN		4. DATE OF DEATH Month Sept. Day 21, Year 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 22, 1877
9. AGE (In years last birthday) yrs. 81		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner (rtd)		10b. KIND OF BUSINESS OR INDUSTRY Dry Cleaning	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME Charles W. Coleman		14. MOTHER'S MAIDEN NAME Martha Jane Gobrecht	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Miriam Goldsmith - 236 Rogers Forge Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 10 , 19 52 , to Sept. 22 , 19 58 , that I last saw the deceased alive on Sept. 22 , 19 58 , and that death occurred at 1 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Laurence C. Post M.D.		ADDRESS (Street, city or town, state) 6005 York Rd. Baltimore 12 Md	
PHYSICIAN'S NAME (Type) LAURENCE C. Post			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/24/58	
22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cem.		22d. LOCATION (City, town, or county) (State) Violetville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto 17 Md		24a. SIGNED BY REGISTRAR SEP 24 58	
ADDRESS		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL—3. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9874

CERTIFICATE OF DEATH

09858

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3508 Old Mill Rd.				d. STREET ADDRESS 3508 Old Mill Rd.			
3. NAME OF DECEASED (Type or print) First GEORGE Middle EDWARD Last CONNOR				4. DATE OF DEATH Month September Day 4 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1907	9. AGE (In years last birthday) yrs. 51	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Westinghouse		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland		11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph I. Connor				14. MOTHER'S MAIDEN NAME Mabel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-10-1932		17. INFORMANT George J. Connor - 732 Silver Creek Rd. - 8			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cs of Prostate with metastases 177x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 wks.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 8/15, 1958 , to 9/4, 1958 , that I last saw the deceased alive on 9/3, 1958 , and that death occurred at 5:45 p. m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edwin L. Pierpont		M.D. 8204 LIBERTY Rd		DATE SIGNED 9/5/58			
PHYSICIAN'S NAME (Type) EDWIN L. PIERPONT, MD		BALTO. 7 MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/8/1958	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	22d. LOCATION (City, town, or county)	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost-4600 Liberty Hgts. Ave.			24a. REC'D BY REGISTRAR DATE SEP 8 '58	24b. REGISTRAR'S SIGNATURE C. J. H. H. H.			

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
JAMES M. BROWN		Male		45		1900		Baltimore, Md.		Baltimore, Md.		Heart Disease		1945		10:00 AM		Home		J. M. Brown		J. M. Brown	
Occupation		Marital Status		Education		Religion		Previous Illnesses		Last Medical Examination		Manner of Death		Burial or Disposition		Funeral Home		Burial Place		Date of Burial		Signature of Minister	
Teacher		Married		High School		Roman Catholic		Hypertension		1944		Natural		Buried		St. Mary's		St. Mary's		1945		J. M. Brown	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Burial		Time of Burial		Place of Burial		Signature of Minister		Date of Death		Time of Death		Place of Death	
1945		10:00 AM		Home		J. M. Brown		J. M. Brown		1945		10:00 AM		Home		J. M. Brown		1945		10:00 AM		Home	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9875

CERTIFICATE OF DEATH

09859

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>68 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		3V01-4 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		d. STREET ADDRESS <u>551 Yale Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>E.</u> Last <u>CONNOR</u>		4. DATE OF DEATH Month <u>September</u> Day <u>26</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 20, 1887</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Newspaper Company</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Matthew Connor</u>		14. MOTHER'S MAIDEN NAME <u>Mary Anne Grady</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW I 218-10-6812</u>	
17. INFORMANT <u>Clin. Rec. Vet. Adm. Hosp. Ft. Howard, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>HEPATOMEGALY</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HEPATOMEGALY</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u> <u>4 YEARS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 20, 1958</u> to <u>September 26, 1958</u> , and that death occurred at <u>4:00 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Hiram B. Curry</u> M.D. PHYSICIAN'S NAME (Type) <u>Hiram B. Curry</u> <u>VAH, Fort Howard, Maryland</u> <u>9/26/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-30-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. Howard Strong</u> ADDRESS <u>G. Howard Strong, 3207 W. North Ave. Balto, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 30 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

18839

18839

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>		<p>3. AGE [Faint text]</p>	
<p>4. DATE OF DEATH [Faint text]</p>		<p>5. TIME OF DEATH [Faint text]</p>		<p>6. PLACE OF DEATH [Faint text]</p>	
<p>7. CAUSE OF DEATH [Faint text]</p>		<p>8. MANNER OF DEATH [Faint text]</p>		<p>9. SIGNATURE OF DECEASED [Faint text]</p>	
<p>10. SIGNATURE OF WITNESS [Faint text]</p>		<p>11. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>12. SIGNATURE OF CORONER [Faint text]</p>	
<p>13. SIGNATURE OF JURY [Faint text]</p>		<p>14. SIGNATURE OF JUDGE [Faint text]</p>		<p>15. SIGNATURE OF CLERK [Faint text]</p>	
<p>16. SIGNATURE OF NOTARY [Faint text]</p>		<p>17. SIGNATURE OF SHERIFF [Faint text]</p>		<p>18. SIGNATURE OF DEPUTY SHERIFF [Faint text]</p>	
<p>19. SIGNATURE OF JAILER [Faint text]</p>		<p>20. SIGNATURE OF WARDEN [Faint text]</p>		<p>21. SIGNATURE OF CHIEF CLERK [Faint text]</p>	
<p>22. SIGNATURE OF ASSISTANT CLERK [Faint text]</p>		<p>23. SIGNATURE OF RECEPTION CLERK [Faint text]</p>		<p>24. SIGNATURE OF DISCHARGE CLERK [Faint text]</p>	
<p>25. SIGNATURE OF DEATH CLERK [Faint text]</p>		<p>26. SIGNATURE OF BURIAL CLERK [Faint text]</p>		<p>27. SIGNATURE OF CREMATION CLERK [Faint text]</p>	
<p>28. SIGNATURE OF INTERMENT CLERK [Faint text]</p>		<p>29. SIGNATURE OF RECEPTION CLERK [Faint text]</p>		<p>30. SIGNATURE OF DISCHARGE CLERK [Faint text]</p>	
<p>31. SIGNATURE OF DEATH CLERK [Faint text]</p>		<p>32. SIGNATURE OF BURIAL CLERK [Faint text]</p>		<p>33. SIGNATURE OF CREMATION CLERK [Faint text]</p>	
<p>34. SIGNATURE OF INTERMENT CLERK [Faint text]</p>		<p>35. SIGNATURE OF RECEPTION CLERK [Faint text]</p>		<p>36. SIGNATURE OF DISCHARGE CLERK [Faint text]</p>	
<p>37. SIGNATURE OF DEATH CLERK [Faint text]</p>		<p>38. SIGNATURE OF BURIAL CLERK [Faint text]</p>		<p>39. SIGNATURE OF CREMATION CLERK [Faint text]</p>	
<p>40. SIGNATURE OF INTERMENT CLERK [Faint text]</p>		<p>41. SIGNATURE OF RECEPTION CLERK [Faint text]</p>		<p>42. SIGNATURE OF DISCHARGE CLERK [Faint text]</p>	
<p>43. SIGNATURE OF DEATH CLERK [Faint text]</p>		<p>44. SIGNATURE OF BURIAL CLERK [Faint text]</p>		<p>45. SIGNATURE OF CREMATION CLERK [Faint text]</p>	
<p>46. SIGNATURE OF INTERMENT CLERK [Faint text]</p>		<p>47. SIGNATURE OF RECEPTION CLERK [Faint text]</p>		<p>48. SIGNATURE OF DISCHARGE CLERK [Faint text]</p>	
<p>49. SIGNATURE OF DEATH CLERK [Faint text]</p>		<p>50. SIGNATURE OF BURIAL CLERK [Faint text]</p>		<p>51. SIGNATURE OF CREMATION CLERK [Faint text]</p>	
<p>52. SIGNATURE OF INTERMENT CLERK [Faint text]</p>		<p>53. SIGNATURE OF RECEPTION CLERK [Faint text]</p>		<p>54. SIGNATURE OF DISCHARGE CLERK [Faint text]</p>	
<p>55. SIGNATURE OF DEATH CLERK [Faint text]</p>		<p>56. SIGNATURE OF BURIAL CLERK [Faint text]</p>		<p>57. SIGNATURE OF CREMATION CLERK [Faint text]</p>	
<p>58. SIGNATURE OF INTERMENT CLERK [Faint text]</p>		<p>59. SIGNATURE OF RECEPTION CLERK [Faint text]</p>		<p>60. SIGNATURE OF DISCHARGE CLERK [Faint text]</p>	
<p>61. SIGNATURE OF DEATH CLERK [Faint text]</p>		<p>62. SIGNATURE OF BURIAL CLERK [Faint text]</p>		<p>63. SIGNATURE OF CREMATION CLERK [Faint text]</p>	
<p>64. SIGNATURE OF INTERMENT CLERK [Faint text]</p>		<p>65. SIGNATURE OF RECEPTION CLERK [Faint text]</p>		<p>66. SIGNATURE OF DISCHARGE CLERK [Faint text]</p>	
<p>67. SIGNATURE OF DEATH CLERK [Faint text]</p>		<p>68. SIGNATURE OF BURIAL CLERK [Faint text]</p>		<p>69. SIGNATURE OF CREMATION CLERK [Faint text]</p>	
<p>70. SIGNATURE OF INTERMENT CLERK [Faint text]</p>		<p>71. SIGNATURE OF RECEPTION CLERK [Faint text]</p>		<p>72. SIGNATURE OF DISCHARGE CLERK [Faint text]</p>	
<p>73. SIGNATURE OF DEATH CLERK [Faint text]</p>		<p>74. SIGNATURE OF BURIAL CLERK [Faint text]</p>		<p>75. SIGNATURE OF CREMATION CLERK [Faint text]</p>	
<p>76. SIGNATURE OF INTERMENT CLERK [Faint text]</p>		<p>77. SIGNATURE OF RECEPTION CLERK [Faint text]</p>		<p>78. SIGNATURE OF DISCHARGE CLERK [Faint text]</p>	
<p>79. SIGNATURE OF DEATH CLERK [Faint text]</p>		<p>80. SIGNATURE OF BURIAL CLERK [Faint text]</p>		<p>81. SIGNATURE OF CREMATION CLERK [Faint text]</p>	
<p>82. SIGNATURE OF INTERMENT CLERK [Faint text]</p>		<p>83. SIGNATURE OF RECEPTION CLERK [Faint text]</p>		<p>84. SIGNATURE OF DISCHARGE CLERK [Faint text]</p>	
<p>85. SIGNATURE OF DEATH CLERK [Faint text]</p>		<p>86. SIGNATURE OF BURIAL CLERK [Faint text]</p>		<p>87. SIGNATURE OF CREMATION CLERK [Faint text]</p>	
<p>88. SIGNATURE OF INTERMENT CLERK [Faint text]</p>		<p>89. SIGNATURE OF RECEPTION CLERK [Faint text]</p>		<p>90. SIGNATURE OF DISCHARGE CLERK [Faint text]</p>	
<p>91. SIGNATURE OF DEATH CLERK [Faint text]</p>		<p>92. SIGNATURE OF BURIAL CLERK [Faint text]</p>		<p>93. SIGNATURE OF CREMATION CLERK [Faint text]</p>	
<p>94. SIGNATURE OF INTERMENT CLERK [Faint text]</p>		<p>95. SIGNATURE OF RECEPTION CLERK [Faint text]</p>		<p>96. SIGNATURE OF DISCHARGE CLERK [Faint text]</p>	
<p>97. SIGNATURE OF DEATH CLERK [Faint text]</p>		<p>98. SIGNATURE OF BURIAL CLERK [Faint text]</p>		<p>99. SIGNATURE OF CREMATION CLERK [Faint text]</p>	
<p>100. SIGNATURE OF INTERMENT CLERK [Faint text]</p>		<p>101. SIGNATURE OF RECEPTION CLERK [Faint text]</p>		<p>102. SIGNATURE OF DISCHARGE CLERK [Faint text]</p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH, BALTIMORE, MD. IT IS NOT VALID FOR ANY OTHER PURPOSES.

9876

CERTIFICATE OF DEATH

09860

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.				c. LENGTH OF STAY IN 1b 62 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
				d. STREET ADDRESS 2036 Linden Avenue			
3. NAME OF DECEASED (Type or print) First MAURICE Middle J. Last CONSIDINE				4. DATE OF DEATH Month September Day 17 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 8, 1894	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Wood Factory		11. BIRTHPLACE (State or foreign country) Wilkes-Barre, Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John J. Considine				14. MOTHER'S MAIDEN NAME Mary Danothy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW I 214-10-6860		17. INFORMANT Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA WITH METASTASES TO LIVER, 162.1 LYMPH NODES AND ADRENALS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 17, 1958 , to Sept. 17, 1958 , and that death occurred at 6:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, FORT HOWARD, MARYLAND 9/19/58							
ACTUAL SIGNATURE Chien Wei Lan				PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9-22-58		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	
22d. LOCATION (City, town, or county) (State) Baltimore, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.				24a. REC'D BY REGISTRAR SEP 24 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male	
3. DATE OF BIRTH May 19, 1928		4. PLACE OF BIRTH Jackson, Tennessee	
5. DATE OF DEATH April 4, 1968		6. PLACE OF DEATH Memphis, Tennessee	
7. TIME OF DEATH 2:01 PM		8. CAUSE OF DEATH Shot - Gun	
9. MANNER OF DEATH Suicide		10. PLACE OF INTERMENT None	
11. SIGNATURE OF DECEASED None		12. SIGNATURE OF WITNESSES None	
13. SIGNATURE OF PHYSICIAN None		14. SIGNATURE OF CORONER None	
15. SIGNATURE OF REGISTRAR None		16. SIGNATURE OF CLERK None	
17. SIGNATURE OF JUDGE None		18. SIGNATURE OF SHERIFF None	
19. SIGNATURE OF DISTRICT ATTORNEY None		20. SIGNATURE OF COUNTY CLERK None	
21. SIGNATURE OF CITY CLERK None		22. SIGNATURE OF MAYOR None	
23. SIGNATURE OF COMMISSIONER None		24. SIGNATURE OF GOVERNOR None	
25. SIGNATURE OF PRESIDENT None		26. SIGNATURE OF VICE PRESIDENT None	
27. SIGNATURE OF SENATE None		28. SIGNATURE OF HOUSE OF REPRESENTATIVES None	
29. SIGNATURE OF SUPREME COURT None		30. SIGNATURE OF COURTS None	
31. SIGNATURE OF JUDGES None		32. SIGNATURE OF CLERKS None	
33. SIGNATURE OF DEPUTY CLERKS None		34. SIGNATURE OF RECORDERS None	
35. SIGNATURE OF CLERKS None		36. SIGNATURE OF DEPUTY CLERKS None	
37. SIGNATURE OF RECORDERS None		38. SIGNATURE OF CLERKS None	
39. SIGNATURE OF DEPUTY CLERKS None		40. SIGNATURE OF RECORDERS None	
41. SIGNATURE OF CLERKS None		42. SIGNATURE OF DEPUTY CLERKS None	
43. SIGNATURE OF RECORDERS None		44. SIGNATURE OF CLERKS None	
45. SIGNATURE OF DEPUTY CLERKS None		46. SIGNATURE OF RECORDERS None	
47. SIGNATURE OF CLERKS None		48. SIGNATURE OF DEPUTY CLERKS None	
49. SIGNATURE OF RECORDERS None		50. SIGNATURE OF CLERKS None	
51. SIGNATURE OF DEPUTY CLERKS None		52. SIGNATURE OF RECORDERS None	
53. SIGNATURE OF CLERKS None		54. SIGNATURE OF DEPUTY CLERKS None	
55. SIGNATURE OF RECORDERS None		56. SIGNATURE OF CLERKS None	
57. SIGNATURE OF DEPUTY CLERKS None		58. SIGNATURE OF RECORDERS None	
59. SIGNATURE OF CLERKS None		60. SIGNATURE OF DEPUTY CLERKS None	
61. SIGNATURE OF RECORDERS None		62. SIGNATURE OF CLERKS None	
63. SIGNATURE OF DEPUTY CLERKS None		64. SIGNATURE OF RECORDERS None	
65. SIGNATURE OF CLERKS None		66. SIGNATURE OF DEPUTY CLERKS None	
67. SIGNATURE OF RECORDERS None		68. SIGNATURE OF CLERKS None	
69. SIGNATURE OF DEPUTY CLERKS None		70. SIGNATURE OF RECORDERS None	
71. SIGNATURE OF CLERKS None		72. SIGNATURE OF DEPUTY CLERKS None	
73. SIGNATURE OF RECORDERS None		74. SIGNATURE OF CLERKS None	
75. SIGNATURE OF DEPUTY CLERKS None		76. SIGNATURE OF RECORDERS None	
77. SIGNATURE OF CLERKS None		78. SIGNATURE OF DEPUTY CLERKS None	
79. SIGNATURE OF RECORDERS None		80. SIGNATURE OF CLERKS None	
81. SIGNATURE OF DEPUTY CLERKS None		82. SIGNATURE OF RECORDERS None	
83. SIGNATURE OF CLERKS None		84. SIGNATURE OF DEPUTY CLERKS None	
85. SIGNATURE OF RECORDERS None		86. SIGNATURE OF CLERKS None	
87. SIGNATURE OF DEPUTY CLERKS None		88. SIGNATURE OF RECORDERS None	
89. SIGNATURE OF CLERKS None		90. SIGNATURE OF DEPUTY CLERKS None	
91. SIGNATURE OF RECORDERS None		92. SIGNATURE OF CLERKS None	
93. SIGNATURE OF DEPUTY CLERKS None		94. SIGNATURE OF RECORDERS None	
95. SIGNATURE OF CLERKS None		96. SIGNATURE OF DEPUTY CLERKS None	
97. SIGNATURE OF RECORDERS None		98. SIGNATURE OF CLERKS None	
99. SIGNATURE OF DEPUTY CLERKS None		100. SIGNATURE OF RECORDERS None	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3877

CERTIFICATE OF DEATH

09861

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Somerset ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.		c. LENGTH OF STAY IN 1b 49 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne 19X-2	
3. NAME OF DECEASED (Type or print) First JOHN Middle — Last COTTMAN		4. DATE OF DEATH Month September Day 28 Year 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 17, 1889
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 6 Days 19 Hours 58 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butler (unemployed)		10b. KIND OF BUSINESS OR INDUSTRY Private Family	
11. BIRTHPLACE (State or foreign country) Princess Anne, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Cottman		14. MOTHER'S MAIDEN NAME Julia Tilghman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I	
17. INFORMANT Clin. Rec. Vet. Adm. Hosp. Fort Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA BILATERAL 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY EDEMA AND CONGESTION AND CARDIOMEGLAY			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that VA attended the deceased from August 10 19 58 , to September 28 19 58 , and that death occurred at 12:40P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 9/29/58 ACTUAL SIGNATURE Chien Wei Lan M.D. _____ PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M. D. VAH, Fort Howard, Md. 9/29/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/5/58	
22c. NAME OF CEMETERY OR CREMATORY Wesley Cemetery		22d. LOCATION (City, town, or county) _____ (State) _____ Princess Anne, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William H. James, Jr.		ADDRESS Princess Anne, Maryland	
24a. REC'D BY REGISTRAR DATE OCT 2 58		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

CERTIFICATE OF DEATH

9878

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X 424 Dunkirk Road.,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 424 Dunkirk Road.,				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edward Middle Roe Last Day				4. DATE OF DEATH Month 9 Day 18 Year 19 58			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-27-92	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 65 Days 65 Hours 65 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Architect				10b. KIND OF BUSINESS OR INDUSTRY Building Trade		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Preston Day				14. MOTHER'S MAIDEN NAME Mary Insley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 218-10-5372		17. INFORMANT Mrs Irene M. Day Address 424 Dunkirk Road.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung DUE TO 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastatic carcinoma DUE TO 1 yr. (c) 1 yr.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. Month 19 Day 19 Year 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 19 57 to Aug 18 19 58 , that I last saw the deceased alive on Aug 18 19 58 , and that death occurred at 7:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2824 ST. PAUL ST Baltimore DATE SIGNED Aug 18 19 58							
ACTUAL SIGNATURE Herbert M. Foster M.D. 2824 ST. PAUL ST Baltimore							
PHYSICIAN'S NAME (Type) HERBERT M. FOSTER 2824 ST. PAUL ST Baltimore							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/22/58		22c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		22d. LOCATION (City, town, or county) (State) Wilmington, Del	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook-Towson Inc. Towson4, Md.				24a. REC'D BY REGISTRAR SEP 22 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be attached with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9879

CERTIFICATE OF DEATH

Reg. Dist. No.

09863

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 2 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 3030 Mandawmin Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First OSCAR Middle DEAN Last		4. DATE OF DEATH Month September Day 3 Year 19 58	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 28, 1897
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - Cooper		12. KIND OF BUSINESS OR INDUSTRY Manufacturing Co.	
13. BIRTHPLACE (State or foreign country) Grovia, Georgia		14. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. FATHER'S NAME Charles Dean		16. MOTHER'S MAIDEN NAME Hannah Brown	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		18. SOCIAL SECURITY NO. 215-05-7823	
19. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA AND CONGESTION 443X DUE TO HYPERTENSIVE CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 1/2 Days 13 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 1, 19 58 to September 3, 19 58 and that death occurred at 6:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VA HOSPITAL, FORT HOWARD, MARYLAND 9/4/58			
ACTUAL SIGNATURE Chien Wei Lan		M.D. VA HOSPITAL, FORT HOWARD, MARYLAND 9/4/58	
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-8-58	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law Mortuary		24a. REC'D BY REGISTRAR DATE SEP 8 '58	
ADDRESS 802-04 Madison Ave. Baltimore 1, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9880

CERTIFICATE OF DEATH

09864

Reg. Dist. No.

1. PLACE OF DEATH <u>Rosewood State Training School</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Baltimore</u>	MARYLAND	a. STATE <u>Maryland</u>	b. COUNTY <u>BALTO.</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 22, Maryland 53</u>	
c. LENGTH OF STAY IN 1b <u>3 months</u>		d. STREET ADDRESS <u>7423 Holabird Avenue</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Donald</u> Middle <u>Lee</u> Last <u>Deere</u>		4. DATE OF DEATH Month <u>9</u> Day <u>21</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/25/56</u>
9. AGE (In years lost birthday) <u>2</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Phillip Deere, Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Emily Lavene Dujardin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Rosewood Records</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 759.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Dehydration, insidious</u> DUE TO (c) <u>Dysautonomia, congenital</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/9/58</u> , 19 <u> </u> , to <u>9/21/58</u> , 19 <u> </u> , that I last saw the deceased alive on <u>9/21/58</u> , 19 <u> </u> , and that death occurred at <u>11:20a</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>9/22/58</u> ACTUAL SIGNATURE <u>Rich. Lindenberg (Ph)</u> M.D. PHYSICIAN'S NAME (Type) <u>Rich. Lindenberg (Ph)</u> <u>707 Fleet Street Balto 2</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/24/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BELAIR MEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BELAIR, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Bush Bradley, Funeral Hl.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 24 58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

Item 18 Film 233 9-18-58 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

09865

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 13 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 5935 Falls Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle Frank Last Dickerson		4. DATE OF DEATH Month September Day 11 Year 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 1, 1926
9. AGE (In years last birthday) 32 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardner		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.A.			
13. FATHER'S NAME Martin Arthur Dickerson		14. MOTHER'S MAIDEN NAME Millie Jane Keith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes 1944-46		16. SOCIAL SECURITY NO. 216-20-8256	
17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency due to 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO (c) Coronary arteriosclerosis associated with occlusion			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE George M. Kieffer		DATE SIGNED 9-11-58	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept 15/58	22c. NAME OF CEMETERY OR CREMATORY Bosley Cemetery	22d. LOCATION (City, town, or county) (State) Balto Co, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Austin E. Donovan - 3818 Roland Ave		24a. REC'D BY REGISTRAR SEP 15 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1010 Leeds Ave.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9882

CERTIFICATE OF DEATH

09866

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
3. NAME OF DECEASED (Served As: First <u>Charles</u> Middle <u>G.</u> Last <u>Brown</u>) (Type or print) <u>JOSEPH G. DIGGS</u>		f. DATE OF DEATH Month <u>September</u> Day <u>13</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/22/83</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u>74</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Collector</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Life Insurance</u>	
13. FATHER'S NAME <u>Joseph C. Diggs</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>212-05-3607</u>	
17. INFORMANT <u>Clin. Records, Vets. Adm. Hospital, Ft. Howard, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF PANCREAS</u> <u>157X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>WITH OBSTRUCTION OF COMMON BILE DUCT</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>September 4, 19 58</u> , to <u>Sept. 13, 19 58</u> , that I saw the deceased alive on <u>September 13, 19 58</u> , and that death occurred at <u>2:30 A. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chien Wei Lan</u>		M.D. <u>VAH, FORT HOWARD, MARYLAND</u>	
PHYSICIAN'S NAME (Type) <u>CHIEN WEI LAN, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 17, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Co. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Horace F. Burgee</u>		ADDRESS <u>Burgess Funeral Home, 3631 Falls Rd, Balto. Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 16 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

CERTIFICATE OF DEATH

1902

PLACE OF BIRTH (Country, State, and County)		PLACE OF DEATH (Country, State, and County)	
DATE OF BIRTH (Month, Day, Year)		DATE OF DEATH (Month, Day, Year)	
SEX Male Female		RACE White Black Other	
OCCUPATION (If deceased, state occupation of decedent)		CAUSE OF DEATH (State in full, and give medical history)	
PLACE OF DEATH (If different from place of birth)		MANNER OF DEATH (Natural, Accidental, Suicide, Homicide, Unknown)	
SIGNATURE OF DECEASED (If living, state name and address)		SIGNATURE OF WITNESSES (If living, state name and address)	
SIGNATURE OF PHYSICIAN (If living, state name and address)		SIGNATURE OF CORONER (If living, state name and address)	
SIGNATURE OF JUDGE (If living, state name and address)		SIGNATURE OF CLERK (If living, state name and address)	
SIGNATURE OF NOTARY (If living, state name and address)		SIGNATURE OF SHERIFF (If living, state name and address)	
SIGNATURE OF TOWNSHIP CLERK (If living, state name and address)		SIGNATURE OF COUNTY CLERK (If living, state name and address)	
SIGNATURE OF STATE CLERK (If living, state name and address)		SIGNATURE OF FEDERAL CLERK (If living, state name and address)	

This certificate is to be filled out by the physician or coroner, and is to be filed in the office of the State Department of Health, Baltimore, Maryland. It is to be filled out in full, and is to be signed by the physician or coroner, and is to be filed in the office of the State Department of Health, Baltimore, Maryland. It is to be filled out in full, and is to be signed by the physician or coroner, and is to be filed in the office of the State Department of Health, Baltimore, Maryland.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09867

9883

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Williamson Mahogany Veneer Co.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NORMAN Middle WILMER Last DRENNING				4. DATE OF DEATH Month September Day 25 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 17, 1935		9. AGE (In years last birthday) 22 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Yard Foreman		10b. KIND OF BUSINESS OR INDUSTRY Veneers Incorp.		11. BIRTHPLACE (State or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Carl Louis Drenning				14. MOTHER'S MAIDEN NAME Agnes Virginia White			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 200-28-3371		17. INFORMANT Family records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to drowning 929.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH:							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell into quarry					
20c. TIME OF INJURY Hour 3:00 p. m. Month, Day, Year 9/25 19 58	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Quarry		20f. (City or town) Cockeysville	(County) Balto.	(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Petty				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/26/58	
EXAMINER'S NAME (Type) Charles S. Petty				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/29/58		22c. NAME OF CEMETERY OR CREMATORY Jessops Cemetery		22d. LOCATION (City, town, or county) (State) Cockeysville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns Sons				ADDRESS Towson 4, Md.		24a. REC'D BY REGISTRAR SEP 30 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. Evans			

MEDICAL CERTIFICATION

Значит, Γ — редукция

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1000-1100-1200-1300-1400-1500-1600-1700-1800-1900-2000-2100-2200-2300-2400-2500-2600-2700-2800-2900-3000-3100-3200-3300-3400-3500-3600-3700-3800-3900-4000-4100-4200-4300-4400-4500-4600-4700-4800-4900-5000-5100-5200-5300-5400-5500-5600-5700-5800-5900-6000-6100-6200-6300-6400-6500-6600-6700-6800-6900-7000-7100-7200-7300-7400-7500-7600-7700-7800-7900-8000-8100-8200-8300-8400-8500-8600-8700-8800-8900-9000-9100-9200-9300-9400-9500-9600-9700-9800-9900-10000-10100-10200-10300-10400-10500-10600-10700-10800-10900-11000-11100-11200-11300-11400-11500-11600-11700-11800-11900-12000-12100-12200-12300-12400-12500-12600-12700-12800-12900-13000-13100-13200-13300-13400-13500-13600-13700-13800-13900-14000-14100-14200-14300-14400-14500-14600-14700-14800-14900-15000-15100-15200-15300-15400-15500-15600-15700-15800-15900-16000-16100-16200-16300-16400-16500-16600-16700-16800-16900-17000-17100-17200-17300-17400-17500-17600-17700-17800-17900-18000-18100-18200-18300-18400-18500-18600-18700-18800-18900-19000-19100-19200-19300-19400-19500-19600-19700-19800-19900-20000-20100-20200-20300-20400-20500-20600-20700-20800-20900-21000-21100-21200-21300-21400-21500-21600-21700-21800-21900-22000-22100-22200-22300-22400-22500-22600-22700-22800-22900-23000-23100-23200-23300-23400-23500-23600-23700-23800-23900-24000-24100-24200-24300-24400-24500-24600-24700-24800-24900-25000-25100-25200-25300-25400-25500-25600-25700-25800-25900-26000-26100-26200-26300-26400-26500-26600-26700-26800-26900-27000-27100-27200-27300-27400-27500-27600-27700-27800-27900-28000-28100-28200-28300-28400-28500-28600-28700-28800-28900-29000-29100-29200-29300-29400-29500-29600-29700-29800-29900-30000-30100-30200-30300-30400-30500-30600-30700-30800-30900-31000-31100-31200-31300-31400-31500-31600-31700-31800-31900-32000-32100-32200-32300-32400-32500-32600-32700-32800-32900-33000-33100-33200-33300-33400-33500-33600-33700-33800-33900-34000-34100-34200-34300-34400-34500-34600-34700-34800-34900-35000-35100-35200-35300-35400-35500-35600-35700-35800-35900-36000-36100-36200-36300-36400-36500-36600-36700-36800-36900-37000-37100-37200-37300-37400-37500-37600-37700-37800-37900-38000-38100-38200-38300-38400-38500-38600-38700-38800-38900-39000-39100-39200-39300-39400-39500-39600-39700-39800-39900-40000-40100-40200-40300-40400-40500-40600-40700-40800-40900-41000-41100-41200-41300-41400-41500-41600-41700-41800-41900-42000-42100-42200-42300-42400-42500-42600-42700-42800-42900-43000-43100-43200-43300-43400-43500-43600-43700-43800-43900-44000-44100-44200-44300-44400-44500-44600-44700-44800-44900-45000-45100-45200-45300-45400-45500-45600-45700-45800-45900-46000-46100-46200-46300-46400-46500-46600-46700-46800-46900-47000-47100-47200-47300-47400-47500-47600-47700-47800-47900-48000-48100-48200-48300-48400-48500-48600-48700-48800-48900-49000-49100-49200-49300-49400-49500-49600-49700-49800-49900-50000-50100-50200-50300-50400-50500-50600-50700-50800-50900-51000-51100-51200-51300-51400-51500-51600-51700-51800-51900-52000-52100-52200-52300-52400-52500-52600-52700-52800-52900-53000-53100-53200-53300-53400-53500-53600-53700-53800-53900-54000-54100-54200-54300-54400-54500-54600-54700-54800-54900-55000-55100-55200-55300-55400-55500-55600-55700-55800-55900-56000-56100-56200-56300-56400-56500-56600-56700-56800-56900-57000-57100-57200-57300-57400-57500-57600-57700-57800-57900-58000-58100-58200-58300-58400-58500-58600-58700-58800-58900-59000-59100-59200-59300-59400-59500-59600-59700-59800-59900-60000-60100-60200-60300-60400-60500-60600-60700-60800-60900-61000-61100-61200-61300-61400-61500-61600-61700-61800-61900-62000-62100-62200-62300-62400-62500-62600-62700-62800-62900-63000-63100-63200-63300-63400-63500-63600-63700-63800-63900-64000-64100-64200-64300-64400-64500-64600-64700-64800-64900-65000-65100-65200-65300-65400-65500-65600-65700-65800-65900-66000-66100-66200-66300-66400-66500-66600-66700-66800-66900-67000-67100-67200-67300-67400-67500-67600-67700-67800-67900-68000-68100-68200-68300-68400-68500-68600-68700-68800-68900-69000-69100-69200-69300-69400-69500-69600-69700-69800-69900-70000-70100-70200-70300-70400-70500-70600-70

3/5/2

0.200

John W. Barry, Jr.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9884

Item 2 Film G234 9-29-58 at

CERTIFICATE OF DEATH

09868

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> Towson (Son's Res.)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in The Pines</u>		d. STREET ADDRESS <u>208 Chesapeake Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>EDITH MARY DUGDALE</u> First Middle Last		4. DATE OF DEATH <u>Sept 22 1958</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 16 1860</u>
9. AGE (In years last birthday) <u>97</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>LONDON ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rev. William Kirkus</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Geo. Dugdale</u>	
17. INFORMANT <u>Geo. Dugdale</u>		Address <u>Towson BALTO MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>20 days</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491x</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7-31-</u> , 19 <u>58</u> , to <u>9-22-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-21-</u> , 19 <u>58</u> , and that death occurred at <u>4 P. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u>		M.D. <u>6209 Frederick Ave.,</u> DATE SIGNED <u>9-22-58</u>	
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>		<u>Baltimore - 28, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>Sept 23, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins</u>		ADDRESS <u>Am Co 4905 York Rd</u>	
24a. REC'D BY REGISTRAR <u>SEP 23 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

CERTIFICATE OF DEATH

2584

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. EDUCATION</p> <p>9. RELIGION</p> <p>10. RACE</p> <p>11. COLOR</p> <p>12. HEIGHT</p> <p>13. WEIGHT</p> <p>14. BUILD</p> <p>15. HAIR</p> <p>16. EYES</p> <p>17. SKIN</p> <p>18. TENDRILS</p> <p>19. SCARS</p> <p>20. TATTOOS</p> <p>21. DENTAL</p> <p>22. GLASSES</p> <p>23. OTHER</p>		<p>1. DATE OF DEATH</p> <p>2. TIME OF DEATH</p> <p>3. PLACE OF DEATH</p> <p>4. CAUSE OF DEATH</p> <p>5. MANNER OF DEATH</p> <p>6. MEDICAL HISTORY</p> <p>7. PRESENT ILLNESS</p> <p>8. TREATMENT</p> <p>9. PHYSICIAN</p> <p>10. HOSPITAL</p> <p>11. NURSE</p> <p>12. ASSISTANT</p> <p>13. OTHER</p>
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OFFICIAL RECORD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09869

9885

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 220 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EARL Middle ---- Last DUTTON		4. DATE OF DEATH Month September Day 18 Year 1958	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 1, 1908
9. AGE (In years last birthday) 49		10. IF UNDER 1 YEAR Months 4 Days 18 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grinder		10b. KIND OF BUSINESS OR INDUSTRY Copper Refinery	
11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Dutton		14. MOTHER'S MAIDEN NAME Ella Coleman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 214-03-1996	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA WITH GENERALIZED CARCINOMATOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. Month, Day, Year 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 10 1958 to September 18 1958 , and that death occurred at 11:30 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Chien Wei Lan		DATE SIGNED 9/19/58	
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.		VAH, FORT HOWARD, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-23-58	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Samuel W. Sullivan, Jr.		24a. REC'D BY REGISTRAR DATE 9/22/58	
ADDRESS 1011 N. Arlington Ave. Baltimore, Maryland		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

CERTIFICATE OF DEATH

1955

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]	
4. DATE OF BIRTH [REDACTED]		5. PLACE OF BIRTH [REDACTED]		6. MARITAL STATUS [REDACTED]	
7. OCCUPATION [REDACTED]		8. CAUSE OF DEATH [REDACTED]		9. MANNER OF DEATH [REDACTED]	
10. DATE OF DEATH [REDACTED]		11. PLACE OF DEATH [REDACTED]		12. SIGNATURE OF DECEASED [REDACTED]	
13. SIGNATURE OF WITNESS [REDACTED]		14. SIGNATURE OF PHYSICIAN [REDACTED]		15. SIGNATURE OF CORONER [REDACTED]	
16. SIGNATURE OF JUDGE [REDACTED]		17. SIGNATURE OF CLERK [REDACTED]		18. SIGNATURE OF REGISTRAR [REDACTED]	

4/28/58 [Signature]

9886

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hampstead</u>		c. LENGTH OF STAY IN lb <u>40yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beckleysville Rd.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hampstead</u>	
f. STREET ADDRESS <u>Beckleysville Rd.</u>		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harry C. Ensor</u>		4. DATE OF DEATH Month <u>September</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 2 1886</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Butler, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Ensor</u>		14. MOTHER'S MAIDEN NAME <u>Mary Tracer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u> </u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma prostate gland</u> DUE TO <u>177X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that I attended the deceased from <u>12/10</u> , 19 <u>55</u> , to <u>Sept 16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 15</u> , 19 <u>58</u> , and that death occurred at <u>4:30p</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W H Foward</u>		DATE SIGNED <u>9/16/58</u>	
PHYSICIAN'S NAME (Type) <u>W H Foward M.D.</u>		<u>Manchester, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 19, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Middletown Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Freeland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David Fortenstein</u>		ADDRESS <u>New Freedom, Pa.</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 988 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10963

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard, Md.</u> c. LENGTH OF STAY IN 1b <u>4 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01-4 d. STREET ADDRESS <u>617 W. Saratoga St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>H.</u> Last <u>FISHER, Jr.</u>				4. DATE OF DEATH Month <u>September</u> Day <u>30</u> Year <u>19 58</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 23, 1914</u>		9. AGE (In years last birthday) <u>43 yrs.</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Roofing Company</u>		11. BIRTHPLACE (State or foreign country) <u>Wilmington, N. C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John H. Fisher</u>						14. MOTHER'S MAIDEN NAME <u>Ronnica Moore</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>				16. SOCIAL SECURITY NO. <u>237-03-9997</u>		17. INFORMANT Address <u>Clin Rec. Vet. Adm. Hospital, Ft. Howard, Md.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LACERATION ON ANTERIOR SURFACE OF HEART MUSCLE</u> 902.7 XXXXXX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HEMORRHAGIC PANCREATITIS (TRAUMATIC)</u> XXXXXX (c) <u>MYOCARDITIS, HYPERTENSIVE CARDIOVASCULAR DISEASE</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 HOURS</u> <u>4 HOURS</u> <u>UNKNOWN</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>													
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>FELL OUT OF BED IN VETERANS HOSPITAL, FORT HOWARD, MD.</u>									
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>11:00</u> <u>9/30/58</u> p. m. _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>VA Hospital</u>		20f. (City or town) <u>Fort Howard, Baltimore, Md.</u>		(County) _____		(State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>M B Davis</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
EXAMINER'S NAME (Type) <u>MELVIN B. DAVIS, M. D.</u>						DATE SIGNED <u>10/2/58</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10-6-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>				22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arlington S. Phillips, 1808-10 N. Monroe St.</u>						ADDRESS <u>Balto 17, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE OCT 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please advise the chief medical examiner, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MAILED 11/10/40

RECEIVED
FBI
NOV 10 1940

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____
2. AGE: _____
3. SEX: _____
4. RACE: _____
5. DATE OF BIRTH: _____
6. PLACE OF BIRTH: _____
7. OCCUPATION: _____
8. MARITAL STATUS: _____
9. EDUCATION: _____
10. RELIGION: _____
11. SOCIAL SECURITY NUMBER: _____
12. DATE OF DEATH: _____
13. TIME OF DEATH: _____
14. PLACE OF DEATH: _____
15. CAUSE OF DEATH: _____
16. MANNER OF DEATH: _____
17. SIGNATURE OF EXAMINER: _____
18. SIGNATURE OF WITNESS: _____
19. SIGNATURE OF CORONER: _____
20. SIGNATURE OF JURY: _____
21. SIGNATURE OF DISTRICT ATTORNEY: _____
22. SIGNATURE OF SHERIFF: _____
23. SIGNATURE OF CLERK: _____
24. SIGNATURE OF NURSE: _____
25. SIGNATURE OF PHYSICIAN: _____
26. SIGNATURE OF CHURCH CLERGY: _____
27. SIGNATURE OF OTHER: _____
28. SIGNATURE OF OTHER: _____
29. SIGNATURE OF OTHER: _____
30. SIGNATURE OF OTHER: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9888 CERTIFICATE OF DEATH

Reg. Dist. No. 9871

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Forest Haven Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sarah Middle Alice Last Geise		4. DATE OF DEATH Month Sept. Day 24 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 19, 1863
9. AGE (In years lost birthday) 95 yrs.		10. IF UNDER 1 YEAR Months 95 Days 95 Hours 95 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Levi Heilman		14. MOTHER'S MAIDEN NAME Elizabeth Berkheimer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Geo. Schield 8642 Pulaski Hwy. Balto. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO-SCLEROTIC CORONARY-ARTERIAL DISEASE DUE TO DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PULMONARY EDEMA DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 9 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/1 , 19 58 , to 9/24 , 19 58 , that I last saw the deceased alive on 9/24 , 19 58 , and that death occurred at 7:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE John H. Shaw M.D.		5800 EDMONSON AVE. 9/24/58	
PHYSICIAN'S NAME (Type) John H. Shaw M.D.		BALTIMORE, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/27/1958	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Easton Bone		ADDRESS Catonsville, Md.	
24a. REC'D BY REGISTRAR DATE SEP 30 1958		24b. REGISTRAR'S SIGNATURE Arthur L. Knaus	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9889 CERTIFICATE OF DEATH

09872

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Tally-Ho Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle PATRICK Last GIBBONS		4. DATE OF DEATH Month September Day 13 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1871
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 87 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Contractor	
11. BIRTHPLACE (State or foreign country) Dublin, Ireland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Gibbons		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-09-3917	
17. INFORMANT Mrs. John F. Amer - Tally-Ho Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease DUE TO 10 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 Month 11 Day 11 Year 1958 a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 11, 1958 , to Sept. 13, 1958 , that I last saw the deceased alive on Sept. 13, 1958 , and that death occurred at 11:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5628 Loch Raven Blvd. (12) DATE SIGNED 9/15/58			
ACTUAL SIGNATURE Worth B. Daniels, Jr.		M.D. 5628 Loch Raven Blvd. (12)	
PHYSICIAN'S NAME (Type) Worth B. Daniels, Jr. - M.D.		5628 Loch Raven Blvd.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/17/1958	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		24a. REC'D BY REGISTRAR SEP 18 1958	
24b. REGISTRAR'S SIGNATURE Charles L. Knead			

TO HOSPITAL BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9890

CERTIFICATE OF DEATH

09873

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore, Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>3 Yrs 01.4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stella Maris Hospice</u>		d. STREET ADDRESS <u>1303 John Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Ann</u> Middle <u>Isador</u> Last <u>Gorman</u>		4. DATE OF DEATH Month <u>9</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/29/1875</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>16</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Patrick Gorman</u>		14. MOTHER'S MAIDEN NAME <u>Mary Blondell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Ralph B. Powers, Jr.</u>		18. ADDRESS (Street, city or town, state) <u>835 Benninghau Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 13, 1958</u> to <u>Sept 16, 1958</u> , that I last saw the deceased alive on <u>Sept 14, 1958</u> , and that death occurred at <u>12:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		DATE SIGNED <u>9/16/58</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Charles F. O'Donnell</u>		ADDRESS (Street, city or town, state) <u>Towson, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-19-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins & Sons Co., Inc.</u>		ADDRESS <u>4905 York Road, Balto., 12, Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 18 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be relied on by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon permits. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18-

09874

9891

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 8 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3V01-4	
d. STREET ADDRESS 2317 ANNAPOLIS ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ADOLF Middle I Last GRUZINSKI		4. DATE OF DEATH Month SEPTEMBER Day 7 Year 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 5, 1898
9. AGE (In years last birthday) 60		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER		10b. KIND OF BUSINESS OR INDUSTRY BARBER SHOP	
11. BIRTHPLACE (State or foreign country) LITHUANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALEXANDER GRUZINSKI		14. MOTHER'S MAIDEN NAME TILLIE DEHRSA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW-1		16. SOCIAL SECURITY NO. 218-18-5795	
17. INFORMANT CLIN REC VET ADM HOSP FT HOWARD MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 150x IMMEDIATE CAUSE (a) CARCINOMA OF ESOPHAGUS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 YEARS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from AUGUST 30 , 19 58 , to SEPTEMBER 7 , 19 58 , and that death occurred at 5:35 a.m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH FORT HOWARD MARYLAND DATE SIGNED 9-7-58 ACTUAL SIGNATURE L. Bruce Smith M.D. VAH FORT HOWARD MARYLAND 9-7-58 PHYSICIAN'S NAME (Type) L. BRUCE SMITH M.D. VAH FORT HOWARD MARYLAND 9-7-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-10-58	
22c. NAME OF CEMETERY OR CREMATORY ST STANISLAUS		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Home 130 E. Fort Ave		24a. REC'D BY REGISTRAR DATE SEP 9 '58	
24b. REGISTRAR'S SIGNATURE Ciriling L. Krause			

James L McCully Funeral Home 128 E Fort Ave Baltimore 30 Md

9892 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3mths21dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
f. STREET ADDRESS 1914 Valley Road		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Thomas Last Gurdizer		4. DATE OF DEATH Month September Day 12 Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June (10), 1879
9. AGE (In years last birthday) 79		10. IF UNDER 1 YEAR Months 12 Days 12 Hours 19 Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown Retired CARPENTER		12. KIND OF BUSINESS OR INDUSTRY Maryland	
13. BIRTHPLACE (State or foreign country) U. S. A.		14. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. FATHER'S NAME Joseph (George) Gurdizer		16. MOTHER'S MAIDEN NAME Mary Brady	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		18. SOCIAL SECURITY NO. 212-01-9918	
19. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 25 , 19 58 , to Sept. 12 , 19 58 , that I last saw the deceased alive on Sept. 12, 1958 , and that death occurred at 12:00a M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachsler M.D.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 9-12-58	
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) 9-16-58		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Wesley Mem.		22d. LOCATION (City, town, or county) (State) CALVERT Co - MD	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck ADDRESS 5305 Harford		24a. REC'D BY REGISTRAR DATE SEP 15 '58	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9829

CERTIFICATE OF DEATH

Items 11, 12 Film G234 10-15-58 at

09876

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. LENGTH OF STAY IN 1b <u>53 DUNDALK 22</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2967 YORKWAY</u>		d. STREET ADDRESS <u>2967 YORKWAY</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>DAVID</u> Middle <u>BRUCE</u> Last <u>HAMPTON</u>		4. DATE OF DEATH Month <u>9</u> Day <u>6</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 19, 1920</u>
9. AGE (In years last birthday) <u>38</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. KIND OF BUSINESS OR INDUSTRY	
13. BIRTHPLACE (State or foreign country) <u>?</u>		14. CITIZEN OF WHAT COUNTRY? <u>?</u>	
15. FATHER'S NAME <u>AMBROSE B. HAMPTON</u>		16. MOTHER'S MAIDEN NAME <u>LEAH (?)</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>		18. SOCIAL SECURITY NO. <u>227-22-3573</u>	
19. INFORMANT <u>FRIENDS</u>		20. ADDRESS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Re. Lobar pneumonia</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
22c. TIME OF INJURY Month, Day, Year Hour a. <u>9</u> p. m. <u>19</u>		22d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-2</u> , 19 <u>58</u> , to <u>9-2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-2</u> , 19 <u>58</u> , and that death occurred at <u>6:30</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Eugene F. Navy</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Eugene F. Navy MD 7001 Morning Lane Rd Balto 22</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/8/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FLAT GAP</u>		22d. LOCATION (City, town, or county) (State) <u>FOUNT. VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kious</u>		24. REGISTRAR'S SIGNATURE <u>Arthur S. Kious</u>	
24a. REC'D BY REGISTRAR <u>SEP 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kious</u>	

AT 4-2600

Mrs. Chambers:
See E. T. if you get an
application on this cert.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9893

CERTIFICATE OF DEATH

09877

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u>				c. LENGTH OF STAY IN 1b <u>4 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 16, Maryland</u> <u>3 Vol-4</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>				d. STREET ADDRESS <u>5405 Rimmell Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Haransky</u> Last <u>Haransky</u>				4. DATE OF DEATH Month <u>9</u> Day <u>29</u> Year <u>19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/2/50</u>	
9. AGE (In years last birthday) <u>8 7</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>7</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-----</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Dave Haransky</u>				14. MOTHER'S MAIDEN NAME <u>Rose Klein</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>-----</u>				16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Rosewood Records</u> Address <u>-----</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u> <u>513X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Sinusitis</u> DUE TO (c) <u>-----</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u> <u>6 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mongolism - birth</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>-----</u> p. m. <u>-----</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/17/54</u> , 19 <u> </u> , to <u>9/29/58</u> , 19 <u> </u> , that I last saw the deceased alive on <u>9/29/58</u> , 19 <u> </u> , and that death occurred at <u>5:20a</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harry G. Butler</u> M.D.				ADDRESS (Street, city or town, state) <u>Owings Mills, Md.</u> DATE SIGNED <u>9/29/58</u>			
PHYSICIAN'S NAME (Type) <u>Harry G. Butler, M.D.</u>				Rosewood State Training School			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10-1-58</u>		<u>Hebrew Friendship</u>		<u>Balto</u> <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Turner</u> ADDRESS <u>2100 Grotas Place</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

2803

MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1914

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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CERTIFICATE OF DEATH

9894

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks				c. LENGTH OF STAY IN 1b 30 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Thornton Mill Rd.				d. STREET ADDRESS Thornton Mill Rd.			
3. NAME OF DECEASED (Type or print) Samuel John Harmon				4. DATE OF DEATH Month 9 Day 19 Year 58			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-8-1885	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min. 73		IF UNDER 24 HRS. Months 73 Days 73 Hours 73 Min. 73			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) owner				10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Penn.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Daniel Harmon				14. MOTHER'S MAIDEN NAME Henrietta Harmon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. no		17. INFORMANT Sadie G. Harmon Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 180x DUE TO Myeloma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) malignant tumor left kidney DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Right nephrectomy Sept. 1957.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 9/17/1958 , to 9-19-1958 , that I last saw the deceased alive on 9/18/1958 , and that death occurred at 5:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1927 York Rd., TIMONIUM DATE SIGNED 9/19/58							
ACTUAL SIGNATURE M. K. Quinn				M.D. TIMONIUM Md.			
PHYSICIAN'S NAME (Type) M. K. QUINN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-22-58		22c. NAME OF CEMETERY OR CREMATORY Jessops Methodist		22d. LOCATION (City, town, or county) (State) Sparks, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Scott Brooks				ADDRESS 622 York Rd., Towson 4, Md.		24a. REC'D BY REGISTRAR SEP 24 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the above papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES DEPARTMENT OF JUSTICE

1934

Division

Training

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1934

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Department of Justice

Department of Justice

Department of Justice

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1934

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4. may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09879

9895

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN lb <u>113 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>T.</u> Last <u>HARROLL</u>		4. DATE OF DEATH Month <u>September</u> Day <u>13</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/6/24</u>
9. AGE (In years last birthday) <u>33</u> yrs.		IF UNDER 1 YEAR Months <u>33</u> Days <u>33</u> Hours <u>33</u> Min. <u>33</u>	IF UNDER 24 HRS. Months <u>33</u> Days <u>33</u> Hours <u>33</u> Min. <u>33</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Forman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Brass Foundry</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John F. Harroll</u>		14. MOTHER'S MAIDEN NAME <u>Hazel Brewer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>219-14-0696</u>	
17. INFORMANT <u>Clin. Records, Vets. Adm. Hospital, Ft. Howard, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF RIGHT KIDNEY SURGICALLY REMOVED</u> <u>180X</u> XXXX <u>WITH BONY AND LYMPH NODE METASTASES</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>DUE TO</u> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>VA</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 23</u> , 19 <u>58</u> , to <u>Sept. 13</u> , 19 <u>58</u> , and that death occurred at <u>8:40 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chien Wei Lan</u>		DATE SIGNED <u>VAH, FORT HOWARD, MARYLAND</u>	
PHYSICIAN'S NAME (Type) <u>CHIEN WEI LAN, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-16-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>5501 Frederick Ave. Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc.</u>		24a. REC'D BY REGISTRAR <u>SEP 15 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>

TO MAYOR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9830

CERTIFICATE OF DEATH

Reg. Dist. No.

19880

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 DUNDALK 22</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1813 PORTSHIP RD</u>		d. STREET ADDRESS <u>1815 PORTSHIP RD</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMIL ANTHONY HAVELIN</u>		4. DATE OF DEATH Month Day Year <u>9/10/58</u> 19	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 7, 1903</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL</u>	
11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CARL HAVELIN</u>		14. MOTHER'S MAIDEN NAME <u>MARY DAHLGREN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-07-474</u>	
17. INFORMANT <u>CARRIE HALL HAVELIN - SAME</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>180X</u> DUE TO <u>Hypertrophoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>14 May</u> , 19 <u>58</u> , to <u>10 Sept</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9 Sept.</u> , 19 <u>58</u> , and that death occurred at <u>1 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Morris Rainess</u>		ADDRESS (Street, city or town, state) <u>2900 Dunbar Rd. Dundalk, Md.</u>	
DATE SIGNED <u>9-11-58</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/13/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PAK LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. CO., MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Bradley, Dundalk, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>SEP 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>C. J. L. L.</u>	

09881

9896

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE COUNTY		c. LENGTH OF STAY IN 1b 2 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 12,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HOLLY HILL MANOR				d. STREET ADDRESS 1419 GLENDALE ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY L. HEARN				4. DATE OF DEATH Month SEPT. Day 28 Year 1958			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1876		9. AGE (In years lost birthday) 82 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BURTONSVILLE MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ISAAC BURTON				14. MOTHER'S MAIDEN NAME MARGARET M. DUVALL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address MRS. MARGARET BERKEMEIER SAME.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO CORONARY OCCLUSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO SENILITY (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260 X DIABETES MELLITUS						INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 10 years 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1930 , to September 28, 1958 , that I last saw the deceased alive on September 26, 1958 , and that death occurred at 11:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6210 York Road DATE SIGNED ACTUAL SIGNATURE A.S. Chalfant M.D. PHYSICIAN'S NAME (Type) A. S. Chalfant Baltimore, 12, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Oct. 1, 1958		22c. NAME OF CEMETERY OR CREMATORY UNION CEMETERY		22d. LOCATION (City, town, or county) (State) BURTONSVILLE MARYLAND.	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC. BALTIMORE MD				24a. REC'D BY REGISTRAR 2 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur L. ...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09882

CERTIFICATE OF DEATH

Reg. Dist. No.

9897

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 178 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 2531 Guilford Ave	
3. NAME OF DECEASED (Type or print) First ALBERT Middle S Last HERFORD		4. DATE OF DEATH Month September Day 18 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 18, 1897
9. AGE (In years lost birthday) 61 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Tavern	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Meyer Herford		14. MOTHER'S MAIDEN NAME Anna Moylan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 213-18-0192	
17. INFORMANT Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CIRRHOSIS LIVER (WITH ASCITES, JAUNDICE AND COMA) 581.0 DUE TO Duration unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH 8 years			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 24, 1958 to September 18, 1958 and that death occurred at 2:45 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Chien Wei Lan M.D.			
PHYSICIAN'S NAME (Type) CHIENT WEI LAN, M.D. VAH FT HOWARD, MD 9/19/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-22-58	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight		ADDRESS Wm Cook-Blight Inc. 6009 Harford Rd. Balto. Md	
24a. REC'D BY REGISTRAR DATE SEP 24 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

CERTIFICATE OF DEATH

NAME OF DECEASED John Howard		DATE OF DEATH September 18, 1933		PLACE OF DEATH Home	
AGE 45		SEX Male		RACE White	
BIRTH DATE March 23, 1888		BIRTH PLACE Baltimore, Maryland		MARRIAGE DATE None	
OCCUPATION None		EDUCATION None		RELIGION None	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		CERTIFICATE NO. 12345	
SIGNATURE OF PHYSICIAN J. M. Smith		SIGNATURE OF WITNESS J. M. Smith		SIGNATURE OF DECEASED John Howard	
DATE OF SIGNATURE September 18, 1933		DATE OF SIGNATURE September 18, 1933		DATE OF SIGNATURE September 18, 1933	
PLACE OF SIGNATURE Baltimore, Maryland		PLACE OF SIGNATURE Baltimore, Maryland		PLACE OF SIGNATURE Baltimore, Maryland	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9898

CERTIFICATE OF DEATH

09883

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1mthldy	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 2549 McHenry Street	
3. NAME OF DECEASED (Type or print) First Lucinda Middle Simering Last Hesselbacher		4. DATE OF DEATH Month September Day 15 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2, 1867
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months 1 Days 15 Hours 15 Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Simering		14. MOTHER'S MAIDEN NAME Elizabeth Hax	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis, severe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 9, 1958 , to Sept. 15, 1958 , that I last saw the deceased alive on Sept. 15, 1958 , and that death occurred at 3:00a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		DATE 9-15-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Sept. 17, 1958		22b. DATE THEREOF Western Cemetery	
22c. NAME OF CEMETERY OR CREMATORY Edmondson Morgue, Md		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Thomas J. Kenny Inc. Hollins + Gilman		24a. REC'D BY REGISTRAR DATE SEP 17 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

3882

1944

1. NAME OF DECEASED JAMES H. HARRIS		2. PLACE OF BIRTH NEW YORK, N.Y.	
3. DATE OF BIRTH JANUARY 1, 1900		4. PLACE OF DEATH NEW YORK, N.Y.	
5. SEX MALE		6. RACE WHITE	
7. OCCUPATION LABORER		8. MARITAL STATUS MARRIED	
9. NAME OF SPouse MARY HARRIS		10. NAME OF CHILDREN JOHN HARRIS	
11. NAME OF NEXT OF KIN JOHN HARRIS		12. NAME OF PHYSICIAN DR. J. H. HARRIS	
13. NAME OF BURIAL PLACE CATHOLIC CHURCH		14. NAME OF MINISTER FRANK J. HARRIS	
15. NAME OF FUNERAL HOME JOHN HARRIS		16. NAME OF CEMETERY CATHOLIC CHURCH	
17. NAME OF INTERVIEWER JOHN HARRIS		18. NAME OF WITNESS JOHN HARRIS	
19. NAME OF DECEASED'S MOTHER MARY HARRIS		20. NAME OF DECEASED'S FATHER JOHN HARRIS	
21. NAME OF DECEASED'S BROTHER JOHN HARRIS		22. NAME OF DECEASED'S SISTER MARY HARRIS	
23. NAME OF DECEASED'S UNCLE JOHN HARRIS		24. NAME OF DECEASED'S AUNT MARY HARRIS	
25. NAME OF DECEASED'S GRANDFATHER JOHN HARRIS		26. NAME OF DECEASED'S GRANDMOTHER MARY HARRIS	
27. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		28. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
29. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		30. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
31. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		32. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
33. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		34. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
35. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		36. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
37. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		38. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
39. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		40. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
41. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		42. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
43. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		44. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
45. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		46. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
47. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		48. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
49. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		50. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
51. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		52. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
53. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		54. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
55. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		56. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
57. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		58. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
59. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		60. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
61. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		62. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
63. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		64. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
65. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		66. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
67. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		68. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
69. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		70. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
71. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		72. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
73. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		74. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
75. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		76. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
77. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		78. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
79. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		80. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
81. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		82. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
83. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		84. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
85. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		86. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
87. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		88. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
89. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		90. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
91. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		92. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
93. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		94. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
95. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		96. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
97. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		98. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	
99. NAME OF DECEASED'S GREAT-GRANDFATHER JOHN HARRIS		100. NAME OF DECEASED'S GREAT-GRANDMOTHER MARY HARRIS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 10, 11, 12, 13, 14, 17 Film 4234 9-24-58 et

09884

9899

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex d. STREET ADDRESS 834 Brunswick Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) COYA First Middle Last Hioh 4. DATE OF DEATH Sept 20 1958 Month Day Year		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH March 26, 1896 9. AGE (In years last birthday) 62 yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Saylor				14. MOTHER'S MAIDEN NAME Eva Connors			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT George Hioh		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral apoplexy 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) 10 yrs INTERVAL BETWEEN ONSET AND DEATH Sudden							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 1 , 19 58 , to Sept 20 , 19 58 , that I last saw the deceased alive on Sept 20 , 19 58 , and that death occurred at 7 A . M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Balto 6 Md DATE SIGNED 9/21/58 ACTUAL SIGNATURE J M Barrymeyer M.D. PHYSICIAN'S NAME (Type) J M Barrymeyer							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 23, 1958		22c. NAME OF CEMETERY OR CREMATORY Morelands Mem. Park		22d. LOCATION (City, town, or county) (State) Balto. Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John G. ... ADDRESS 118 Eastern Ave. Balto. 21				24a. BY REGISTRAR 23 58 DATE		24b. REGISTRAR'S SIGNATURE ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9900

CERTIFICATE OF DEATH

Reg. Dist. No. 09885

1. PLACE OF DEATH a. COUNTY <i>Balto Co.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Balto.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Calonsville</i>		c. LENGTH OF STAY IN 1b <i>4 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>51 Balto (27)</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calon Ridge Conv. Home</i>				d. STREET ADDRESS <i>4615 Annapolis Rd</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>GEORGE</i> First <i>HOFFMAN</i> Middle Last				4. DATE OF DEATH <i>Sept 20</i> Month <i>1958</i> Day Year			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 20, 1866</i>	9. AGE (In years last birthday) <i>92 yrs.</i>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>ret.</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Henry Hoffman</i>				14. MOTHER'S MAIDEN NAME <i>Catherine Springle</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>Mr. Alberto Amier</i>		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <i>Coronary atherosclerosis</i> DUE TO (c) <i>Age</i>						INTERVAL BETWEEN ONSET AND DEATH <i>Instantaneous</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July</i> 19 <i>1958</i> to <i>9/20</i> 19 <i>58</i> , that I last saw the deceased alive on <i>9/15</i> 19 <i>58</i> , and that death occurred at <i>11:30</i> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Cliff Ratliff, Sr.</i>		M.D. <i>4605 Edmondson av</i>		DATE SIGNED <i>9/22/58</i>			
PHYSICIAN'S NAME (Type) <i>CLIFF RATLIFF, SR.</i>		<i>Balto 29, Md</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9/24/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>London Park</i>		22d. LOCATION (City, town, or county) (State) <i>Balto. Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Marshall Lyon</i>				ADDRESS <i>28</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 24 '58</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur L. Thrall</i>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF REGISTRAR		10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF CLERK		12. SIGNATURE OF WITNESSES	
JAMES EARL RAY		M		35		5-10-38		MEMPHIS, TENN		ATTORNEY AT LAW		SHOOTING		HOMICIDE		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
13. PLACE OF DEATH		14. DATE OF DEATH		15. TIME OF DEATH		16. SEX OF DECEASED		17. AGE OF DECEASED		18. OCCUPATION OF DECEASED		19. CAUSE OF DEATH		20. MANNER OF DEATH		21. SIGNATURE OF REGISTRAR		22. SIGNATURE OF PHYSICIAN		23. SIGNATURE OF CLERK		24. SIGNATURE OF WITNESSES	
MEMPHIS, TENN		5-10-68		10:00 AM		M		35		ATTORNEY AT LAW		SHOOTING		HOMICIDE		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
25. PLACE OF DEATH		26. DATE OF DEATH		27. TIME OF DEATH		28. SEX OF DECEASED		29. AGE OF DECEASED		30. OCCUPATION OF DECEASED		31. CAUSE OF DEATH		32. MANNER OF DEATH		33. SIGNATURE OF REGISTRAR		34. SIGNATURE OF PHYSICIAN		35. SIGNATURE OF CLERK		36. SIGNATURE OF WITNESSES	
MEMPHIS, TENN		5-10-68		10:00 AM		M		35		ATTORNEY AT LAW		SHOOTING		HOMICIDE		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

RECEIVED
MAY 11 1968
BALTIMORE, MD

9901

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 8 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 103 Sollers Point Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JERRY Middle A. Last HOLLEY				4. DATE OF DEATH Month September Day 24 Year 19 58			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 18, 1923	
9. AGE (In years last birthday) 35 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator of tractor				10b. KIND OF BUSINESS OR INDUSTRY Steel Company		11. BIRTHPLACE (State or foreign country) Devon, Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Spencer Holley				14. MOTHER'S MAIDEN NAME Lucy Barnett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II				16. SOCIAL SECURITY NO. 207-16-2059		17. INFORMANT Address Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPERTENSIVE CARDIOVASCULAR DISEASE 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) OBESITY							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from September 16 1958 to September 24 1958 and that death occurred at 6:30 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, FORT HOWARD, MARYLAND 9/24/58							
ACTUAL SIGNATURE Irving Freeman M.D. VAH, FORT HOWARD, MARYLAND							
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 30, 1958		22c. NAME OF CEMETERY OR CREMATORY Baltimore National E		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Gibson Funeral Home				24a. REC'D BY REGISTRAR DATE SEP 25 '58		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9902

CERTIFICATE OF DEATH

09887

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>PENNA.</u> b. COUNTY <u>ALLEGHENY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LUTHERVILLE</u>		c. LENGTH OF STAY IN 1b <u>3 WEEKS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>125 OTHORIDGE RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>CAROLINE</u> Last <u>HOOVER</u>		4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 17, 1883</u>
9. AGE (In years lost birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>5</u> Hours <u>5</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>PITTSBURGH, PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM DIETRICH</u>		14. MOTHER'S MAIDEN NAME <u>ANNA (UNKNOWN)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>DOLORES C. CAROUGE</u>		Address <u>125 OTHORIDGE RD. LUTHERVILLE, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>5 HRS.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>7</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>SEPT. 14TH, 1958</u> , to <u>SEPT. 14TH, 1958</u> , that I last saw the deceased alive on <u>SEPT. 14TH, 1958</u> , and that death occurred at <u>10:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gilbert M. Carouge</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>125 OTHORIDGE RD. 9/15/58</u>	
PHYSICIAN'S NAME (Type) <u>GILBERT M. CAROUGE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>9-15-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SHARON CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>CARNOT, PENNA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Towson, INC</u>		24a. REC'D BY REGISTRAR <u>SEP 15 58</u>	
ADDRESS <u>1050 YORK RD</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09888

Reg. Dist. No.

9903

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex (21)</u>			c. LENGTH OF STAY IN lb 	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Essex (21)</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>340 East Riverside Ave.</u>				d. STREET ADDRESS <u>340 East Riverside Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Joseph</u> Last <u>Hoppert Sr.</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>8</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 11, 1913</u>		9. AGE (In years last birthday) <u>45</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>County Government</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Clarence Elmer Hoppert Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Nina Marie Mc Comb</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-01-7177</u>		17. INFORMANT <u>Margaret H. Hoppert</u>			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>A-S-C-V Disease</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>1278 Mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>				
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>M. B. Davis MD.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>9/8/58</u>	
EXAMINER'S NAME (Type) <u>M. B. Davis MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/11/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Meadow Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>A. A. Co., Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Brudzinski</u>				ADDRESS <u>1407 Eastern Ave</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 10 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

9904

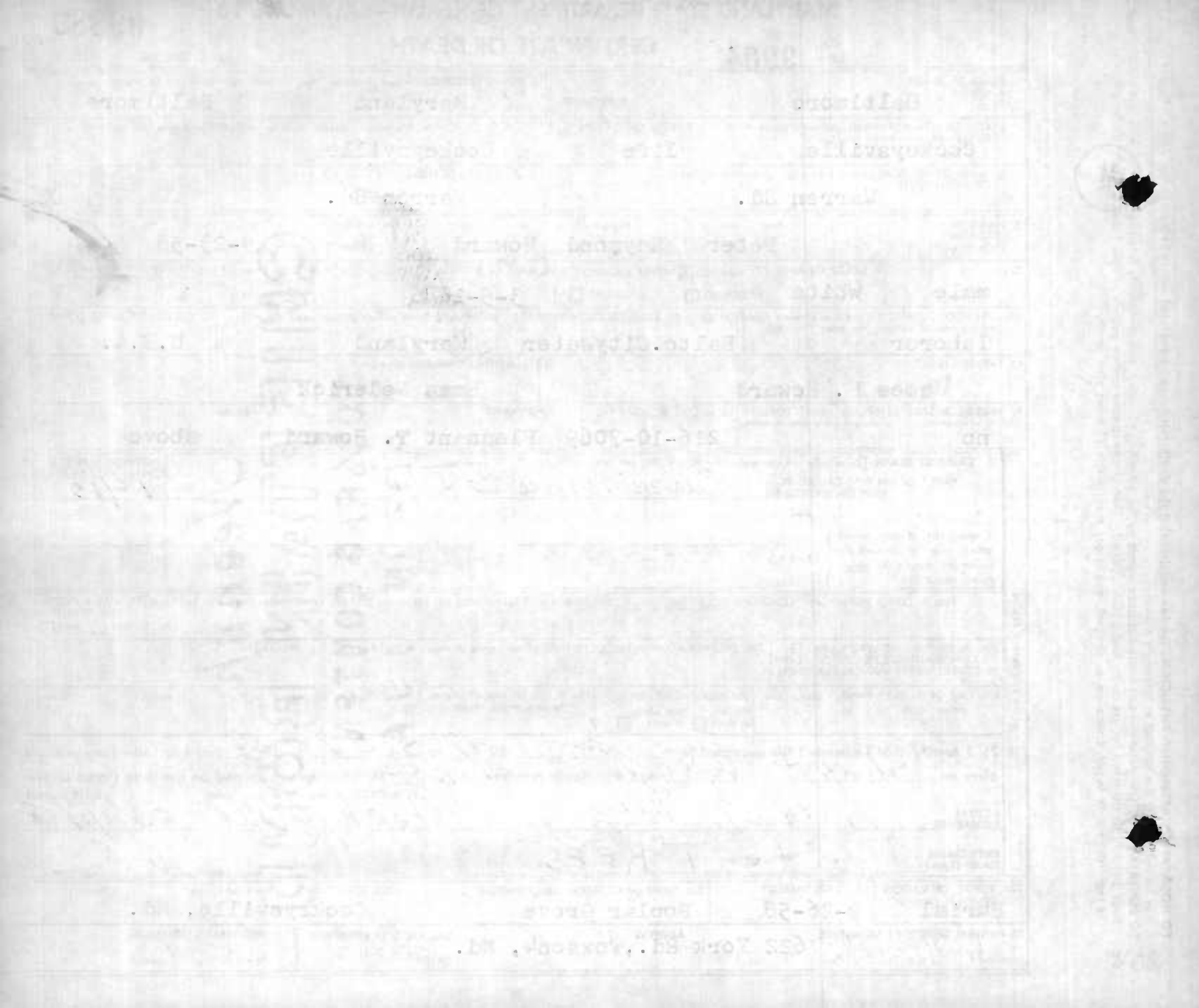
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Warren Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Peter Middle Raymond Last Howard				4. DATE OF DEATH Month 9 Day 23 Year 58			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-5-1886	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer				10b. KIND OF BUSINESS OR INDUSTRY Balto. City Water		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James F. Howard				14. MOTHER'S MAIDEN NAME Emma Hederick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-10-7069		17. INFORMANT Pleasant T. Howard		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Tosis 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH 1965
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Cockeysville				20g. (County) MD		20h. (State) MD	
21. I certify that I attended the deceased from Jan 47 to Sept 58 , that I last saw the deceased alive on 21 Sept 58 , and that death occurred at 11:57 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cockeysville DATE SIGNED 23 Sept 58 ACTUAL SIGNATURE Walter T. Kees M.D. PHYSICIAN'S NAME (Type) Walter T. KEES							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-26-58		22c. NAME OF CEMETERY OR CREMATORY Poplar Grove		22d. LOCATION (City, town, or county) (State) Cockeysville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE L. Scott Brooks				ADDRESS 622 York Rd., Towson 4, Md.		24a. REC'D BY REGISTRAR DATE SEP 25 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kneiss			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9985

CERTIFICATE OF DEATH

09890

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b <u>45 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>→</u>		d. STREET ADDRESS <u>Stone Chapel Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Sara</u> First <u>Wharton</u> Middle <u>Howard</u> Last		4. DATE OF DEATH <u>Sept</u> Month <u>15</u> Day <u>19</u> Year <u>58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 16, 1879</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>Philadelphia-Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George W. Wharton, Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Blakeney Page</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-09-5756E</u>	
17. INFORMANT <u>Miss Josephine Pittward-Daughter-Pikesville</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arterio-sclerosis</u> (c) <u>20 years.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 22</u> , 19 <u>40</u> , to <u>Sept 15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 14</u> , 19 <u>58</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John F. Williams</u> M.D.		ADDRESS (Street, city or town, state) <u>1725 Reisterstown Rd. Pikesville 8. Md.</u>	
PHYSICIAN'S NAME (Type) <u>Palmer F. Williams</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/17/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>UNION</u>		22d. LOCATION (City, town, or county) (State) <u>Leesburg-VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward P. C. - Balto-1-Md</u>		24a. REC'D BY REGISTRAR <u>SEP 17 '58</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY, MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09891

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. LENGTH OF STAY IN 1b 53 Dundalk			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 3600 Old North Pt. Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Samuel Middle B. Last Huey				4. DATE OF DEATH Month 9 Day 23 Year 1958			
5. SEX Male		6. COLOR OR RACE Wh.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 27, 1900	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 58 Days 58 Hours 58 Min.		IF UNDER 24 HRS. Months 58 Days 58 Hours 58 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane repairman				10b. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) Penna.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joseph Huey				14. MOTHER'S MAIDEN NAME Rosa Bostic			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 190-03-4605		17. INFORMANT Address Mrs. Lela Huey, 3600 Old North Point Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerotic Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 10 min 2 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Jack Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 9-23-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Sept. 24, 1958		22c. NAME OF CEMETERY OR CREMATORY East Mahoney Cemetery		22d. LOCATION (City, town, or county) (State) Cherry Tree, Pa	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road.				24a. REC'D BY REGISTRAR DATE SEP 26 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Huns	

9906

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2117 Arlonne Drive</u>				d. STREET ADDRESS <u>1 2117 Arlonne Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GEORG</u> Middle <u>B.</u> Last <u>JERSIN</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>2</u> Year <u>19 58</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 22, 1892</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min. <u>66</u>		11. BIRTHPLACE (State or foreign country) <u>Bergen, Norway</u>		12. CITIZEN OF WHAT COUNTRY? <u>??</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dentistry</u>		11. BIRTHPLACE (State or foreign country) <u>Bergen, Norway</u>	
13. FATHER'S NAME <u>Ludwig Jersin</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs. Pearl D. Jersin - 2117 Arlonne Drive</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> (c) <u>Myocardial Infarction</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 m o.</u> <u>5 mos.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 1, 1945</u> , to <u>Sept. 2, 1958</u> , that I last saw the deceased alive on <u>Sept. 1, 1958</u> , and that death occurred at <u>Md.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Madison Rd. Balto., Md.</u> DATE SIGNED <u>Sept. 4, 1958</u>							
ACTUAL SIGNATURE <u>Robt. B. Wright</u> M.D.				PHYSICIAN'S NAME (Type) <u>Robt. B. Wright</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>9/5/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sam J. Dickner & Sons - Balto 17</u>				24a. REC'D BY REGISTRAR <u>Md.</u>			
24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>				DATE <u>SEP 5 '58</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9907 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) - Baltimore 7		c. LENGTH OF STAY IN 1b 7	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6505 Laurel Drive		d. STREET ADDRESS 6505 Laurel Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MILDRED W. JONES		4. DATE OF DEATH Month Day Year Sept. 28, 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 19, 1906
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. 22	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Carl E. Wosch		14. MOTHER'S MAIDEN NAME Mary L. Pangle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. J. Paul Jones - 6505 Laurel Drive		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE BREAST WITH GENERALIZED METASTASES 170X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 9 m. 19 p. m.	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 19 50 to September 19 58 , that I last saw the deceased alive on 27 September 19 58 , and that death occurred at 5:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5101 Gwynn Oak Avenue, Baltimore, 7, Maryland DATE SIGNED 29 Sept. 1958			
ACTUAL SIGNATURE Millard T. Traband, Jr. M.D.			
PHYSICIAN'S NAME (Type) Millard T. Traband, Jr. M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/1/58	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.	22d. LOCATION (City, town, or county) (State) Pikesville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Chas. J. Pickner		ADDRESS 1700 N. ...	
24a. REC'D BY REGISTRAR 29 '58		24b. REGISTRAR'S SIGNATURE Charles S. ...	

CERTIFICATE OF DEATH

Form No. 10

1. Name of Deceased		2. Sex		3. Age		4. Date of Birth		5. Date of Death	
6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Signature of Registrar	
11. Signature of Physician		12. Signature of Medical Examiner		13. Signature of Coroner		14. Signature of Jury		15. Signature of Witnesses	
16. Signature of Burial Officer		17. Signature of Undertaker		18. Signature of Funeral Home		19. Signature of Cemetery		20. Signature of Church	
21. Signature of Minister		22. Signature of Rector		23. Signature of Pastor		24. Signature of Priest		25. Signature of Rabbi	
26. Signature of Imam		27. Signature of Minister of Religion		28. Signature of Minister of Religion		29. Signature of Minister of Religion		30. Signature of Minister of Religion	
31. Signature of Minister of Religion		32. Signature of Minister of Religion		33. Signature of Minister of Religion		34. Signature of Minister of Religion		35. Signature of Minister of Religion	
36. Signature of Minister of Religion		37. Signature of Minister of Religion		38. Signature of Minister of Religion		39. Signature of Minister of Religion		40. Signature of Minister of Religion	
41. Signature of Minister of Religion		42. Signature of Minister of Religion		43. Signature of Minister of Religion		44. Signature of Minister of Religion		45. Signature of Minister of Religion	
46. Signature of Minister of Religion		47. Signature of Minister of Religion		48. Signature of Minister of Religion		49. Signature of Minister of Religion		50. Signature of Minister of Religion	
51. Signature of Minister of Religion		52. Signature of Minister of Religion		53. Signature of Minister of Religion		54. Signature of Minister of Religion		55. Signature of Minister of Religion	
56. Signature of Minister of Religion		57. Signature of Minister of Religion		58. Signature of Minister of Religion		59. Signature of Minister of Religion		60. Signature of Minister of Religion	
61. Signature of Minister of Religion		62. Signature of Minister of Religion		63. Signature of Minister of Religion		64. Signature of Minister of Religion		65. Signature of Minister of Religion	
66. Signature of Minister of Religion		67. Signature of Minister of Religion		68. Signature of Minister of Religion		69. Signature of Minister of Religion		70. Signature of Minister of Religion	
71. Signature of Minister of Religion		72. Signature of Minister of Religion		73. Signature of Minister of Religion		74. Signature of Minister of Religion		75. Signature of Minister of Religion	
76. Signature of Minister of Religion		77. Signature of Minister of Religion		78. Signature of Minister of Religion		79. Signature of Minister of Religion		80. Signature of Minister of Religion	
81. Signature of Minister of Religion		82. Signature of Minister of Religion		83. Signature of Minister of Religion		84. Signature of Minister of Religion		85. Signature of Minister of Religion	
86. Signature of Minister of Religion		87. Signature of Minister of Religion		88. Signature of Minister of Religion		89. Signature of Minister of Religion		90. Signature of Minister of Religion	
91. Signature of Minister of Religion		92. Signature of Minister of Religion		93. Signature of Minister of Religion		94. Signature of Minister of Religion		95. Signature of Minister of Religion	
96. Signature of Minister of Religion		97. Signature of Minister of Religion		98. Signature of Minister of Religion		99. Signature of Minister of Religion		100. Signature of Minister of Religion	



9908

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockaway Beach				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockaway Beach Balto. Co.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 1 Box 622				d. STREET ADDRESS Route 1 Box 622 Balto. 21		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Victor Kalkowski				4. DATE OF DEATH Month September Day 4 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1878		9. AGE (In years last birthday) yrs. 79	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Iron Moulder		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME (Unknown) JOSEPH KALKOWSKI				14. MOTHER'S MAIDEN NAME (Unknown) KATHERINE SZYMANSKI			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-07-4118A		17. INFORMANT Address Mrs. Eva Kalkowski Rt. 1 Box 622 Balto. 21			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 444 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Essential Hypertension DUE TO (c) Years INTERVAL BETWEEN ONSET AND DEATH Years						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/11/57 to 9/1/58 , 19____, that I last saw the deceased alive on 2/28/58 , 19____, and that death occurred at 4 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Robert J. Lyden, M.D.				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 8, 1958		22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus		22d. LOCATION (City, town, or county) (State) Balto. Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John L. Connolly				ADDRESS 418 Eastern Blvd. Balto. 21		24a. REC'D BY REGISTRAR SEP 9 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. Evans			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in at the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9909

CERTIFICATE OF DEATH

09896

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 152 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION V.A. Hospital		d. STREET ADDRESS 1211 Joplin Street	
3. NAME OF DECEASED (Type or print) First GEORGE Middle J. Last KARPER		4. DATE OF DEATH Month September Day 23 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 5, 1917
9. AGE (In years last birthday) 41 yrs.		10. IF UNDER 1 YEAR: Months 41 Days 19 Hours 58 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Structure/Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Aircraft Mfg. Co.	
11. BIRTHPLACE (State or foreign country) Shenandoah, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Anthony Karper		14. MOTHER'S MAIDEN NAME Mary Zanis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 186-01-5810	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS 163X DUE TO CARCINOMA, RIGHT LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operation: 7/1/58 Laparotomy - Metastatic tumor of small bowel			
INTERVAL BETWEEN ONSET AND DEATH UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
19a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 24 , 19 58 , to September 23 , 19 58 , and that death occurred at 3:50 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Irving Freeman		DATE SIGNED 9/23/58	
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service, VAH, Fort Howard, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sgt. 26-58	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. G. Connelly & Sons		24a. REC'D BY REGISTRAR SEP 25 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9910 CERTIFICATE OF DEATH

09897

Reg. Dist. No.

1. PLACE OF DEATH Rosewood State Training School				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY Baltimore		MARYLAND		a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland		c. LENGTH OF STAY IN 1b 4 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 7, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School				d. STREET ADDRESS 6839 Westridge Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Tina Middle Sue Last Kassel				4. DATE OF DEATH Month 9 Day 4 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/23/53	
9. AGE (In years last birthday) 4 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		11. BIRTHPLACE (State or foreign country) Alaska		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leon Edward Kassell				14. MOTHER'S MAIDEN NAME Gazelle Max Gittleman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Rosewood Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Pneumonia 492x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Premature birth (Idiot - Bed case) DUE TO (c) Birth				INTERVAL BETWEEN ONSET AND DEATH Two weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cong. Cerebral defect of undetermined type (as above)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) (b) Ruptured tumor blood vessel		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Owings Mills, Md		(County) (State)	
21. I certify that I attended the deceased from 9/21/54 , 19____, to 9/4/58 , 19____, that I last saw the deceased alive on 9/4/58 , 19____, and that death occurred at 1:50p M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Darryl B. Butler				ADDRESS (Street, city or town, state) Owings Mills, Md			
PHYSICIAN'S NAME (Type) Rosedale				DATE SIGNED 4 Sept 58			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		9-5-58		St. Catherine		Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis				ADDRESS 2160 Eutaw Place		24a. REC'D BY REGISTRAR DATE SEP 8 58	
						24b. REGISTRAR'S SIGNATURE Arthur S. Hallett	

CERTIFICATE OF DEATH

<p>1. Name of deceased: <i>John Doe</i></p>	
<p>2. Date of death: <i>10/15/1918</i></p>	
<p>3. Place of death: <i>Home</i></p>	
<p>4. Cause of death: <i>Heart failure</i></p>	
<p>5. Signature of physician: <i>Dr. J. H. Smith</i></p>	
<p>6. Signature of registrar: <i>W. H. Jones</i></p>	
<p>7. Signature of informant: <i>John Doe</i></p>	
<p>8. Date of registration: <i>10/16/1918</i></p>	
<p>9. Place of registration: <i>City of New York</i></p>	
<p>10. Registrar's office: <i>City of New York</i></p>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09898

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 10 mos.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 23 Cedarmere Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Brenda Middle Lee Last Kelley		4. DATE OF DEATH Month Sept. Day 13 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1957
9. AGE (In years last birthday) yrs. 10 Months 18		IF UNDER 1 YEAR Hours 18 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Baltimore City, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Theodore E. Kelley		14. MOTHER'S MAIDEN NAME Dorothy Ann Gill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Theodore E. Kelley, Owings Mills, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to Acute Laryngotracheitis 474X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 3 hrs. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. D. Caples		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 9-15-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 16/58	
22c. NAME OF CEMETERY OR CREMATORY Dover Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. E. ine & Sons, Reisterstown, Md.		ADDRESS	
24a. REC'D BY REGISTRAR DATE SEP 17 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2034243XV6

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10-1-1917

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
OFFICE OF EXAMINER: [illegible]

9912

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 35½ Hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 842 W. 33rd Street			
3. NAME OF DECEASED (Type or print) First Middle Last HARRY --- KIMMEL				4. DATE OF DEATH Month Day Year September 24 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 16, 1904	9. AGE (In years and birthday) yrs. 54	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper Hanger				10b. KIND OF BUSINESS OR INDUSTRY Interior Decoration		11. BIRTHPLACE (State or foreign country) La Plata, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Joseph Kimmel				14. MOTHER'S MAIDEN NAME Freida Blumenthal			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II				16. SOCIAL SECURITY NO.		17. INFORMANT Address Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNG WITH WIDESPREAD METASTASES 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) PM		20f. (City or town) (County) (State) AM	
21. I certify that I attended the deceased from Sept. 22, 12:45, 58 to Sept. 24, 12:15, 58 and that death occurred at 12:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Irving Freeman				M.D. VAH, FORT HOWARD, MARYLAND DATE SIGNED 9/24/58			
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 26/58		22c. NAME OF CEMETERY OR CREMATORY Hebrew Friendship Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Sol Levinson & Bros.				ADDRESS 1126 W. North Ave. Baltimore, Maryland		24a. REC'D BY REGISTRAR DATE SEP 26 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

90

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
9913 CERTIFICATE OF DEATH										
Reg. Dist. No. 09960										
1. PLACE OF DEATH a. COUNTY Balto. MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home					d. STREET ADDRESS 4307 Springdale Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHRISTIAN KLIMM					4. DATE OF DEATH Month Sept. Day 29 Year 19 58					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 20, 1876		9. AGE (In years last birthday) 82 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Yard Supt./ (rtd)					10b. KIND OF BUSINESS OR INDUSTRY Iron & Metal		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Andrew Klimm					14. MOTHER'S MAIDEN NAME Rose Bernhardt					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Wm. Blake - 22 Locust Dr., Catonsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 hours 10 years										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes mellitus										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 p. m.					20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1952 , to September , 19 58 , that I last saw the deceased alive on 29 September , 19 58 , and that death occurred at 8:20 P.M. , from the causes and on the date stated above.										
ACTUAL SIGNATURE Millard T. Traband					ADDRESS (Street, city or town, state) 5101 Gwynn Oak Avenue, Baltimore, Md.					
DATE SIGNED 1 October 1958										
PHYSICIAN'S NAME (Type) Millard T. Traband, Jr. M. D. Baltimore, 7, Maryland										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 10/3/58		22c. NAME OF CEMETERY OR CREMATORY Lorraine Maus.			22d. LOCATION (City, town, or county) (State) Woodlawn, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons - Balto					ADDRESS Balto		24a. REC'D BY REGISTRAR 2 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

9914

CERTIFICATE OF DEATH

09901

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7023 Deerfield Rd.		d. STREET ADDRESS 7023 Deerfield Rd.	
3. NAME OF DECEASED (Type or print) First NORMA Middle R. Last KRAMER		4. DATE OF DEATH Month Sept. Day 11. Year 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 15, 1901
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher (rtd)		10b. KIND OF BUSINESS OR INDUSTRY Balto. City	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frederick L. Kramer		14. MOTHER'S MAIDEN NAME Augusta M. Rau	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. W. Kramer - 2645 Purnell Drive		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis & hypertensive CVD DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1 Feb. , 19 56 , to 11 Sept. , 19 58 , that I last saw the deceased alive on 9 July 58 , and that death occurred at 9:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1004 REISTENSTOWN RD., BALTO. (8), MD. DATE SIGNED 13 Sept 58 ACTUAL SIGNATURE Merrill E. Parelhoff M.D. PHYSICIAN'S NAME (Type) MERRILL E. PARELHOFF			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/15/58	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.	22d. LOCATION (City, town, or county) (State) Pikesville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tichner & Sons - Balto. 7th		24a. REC'D BY REGISTRAR SEP 15 58	24b. REGISTRAR'S SIGNATURE Clifford E. Harris

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial-cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09902

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3411 E. Joppa Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3411 E. Joppa Road	
3. NAME OF DECEASED (Type or print) First Middle Last Margaret T. Krokowski		4. DATE OF DEATH Month Day Year Sept. 5 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1912
9. AGE (In years, last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Kreusinger		14. MOTHER'S MAIDEN NAME Elizabeth Seidel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-03-2988	
17. INFORMANT George Krokowski		Address 3411 E. Joppa Road	
18. CAUSE OF DEATH [Enter only one cause possible for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation from hanging DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) Sudden		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Charles F. O'Donnell		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles F. O'Donnell		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/1/58	
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF 9-9-58	
22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John C. Miller Inc.		ADDRESS 2431-35 E. Oliver St.	
24a. REC'D BY REGISTRAR DATE SEP 10 58		24b. REGISTRAR'S SIGNATURE John C. Miller	

9916

CERTIFICATE OF DEATH

09903

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print) ERMA P. KUHNLE		2. DATE OF DEATH Sept. 20, 1958	
3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. Co.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto.	
B. FULL NAME OF HOSPITAL OR INSTITUTION 00 327 Dunkirk Rd.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. X	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 327 Dunkirk Rd.	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Aug. 1, 1907
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home	9. AGE (In years last birthday) 51 If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min.
13. FATHER'S NAME George Plant		11. BIRTHPLACE (State or foreign country) Md.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? WHAT COUNTRY?	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Carrie Mullen	
17. INFORMANT Miss Fanchon Kuhnle - 327 Dunkirk Rd.		ADDRESS	

18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Coronary Occlusion Aorta DUE TO (B) Arteriosclerotic O.V.D. DUE TO (C) WAS PERFORMED YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 hrs
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
20. CAUSE OF DEATH, ENTER IN PART I OR PART II		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from May 30 19 58 to Sept 20 19 58 , that (I) (we) last saw the deceased alive on Sept 17 19 58 , and that death occurred at 2:30 A m., from the causes and on the date stated above.		
23A. SIGNATURE Charles J. [Signature] ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D.	23B. ADDRESS 6207 York Rd	23C. DATE SIGNED 9/22/58
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 9/22/58	24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.
24D. LOCATION (City, town, or county) (State) Balto., Md.	25. FUNERAL DIRECTOR Wm. J. Tiekner & Sons ADDRESS Balto., Md.	
DATE RECEIVED BY LOCAL REGISTRAR SEP 24 58		
REGISTRAR'S SIGNATURE Arthur L. Kraus		

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WRITE WITH BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information should be supplied. Physicians: please write the causes of death clearly and legibly. THIS CERTIFICATE MUST BE FILED IN BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

9917

CERTIFICATE OF DEATH

09904

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. Balto. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto 7,		c. LENGTH OF STAY IN 1b 5 yrs		X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto 7			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Robbs Nursing Home Balto 7				d. STREET ADDRESS 3721 Buckingham Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Carrie Middle E. Last Landes				4. DATE OF DEATH Month 9 Day 9 Year 1958			
5. SEX F.	6. COLOR OR RACE W.	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 13, 1885		9. AGE (In years last birthday) yrs. 72	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing Prof.		11. BIRTHPLACE (State or foreign country) Manchester, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Warner				14. MOTHER'S MAIDEN NAME Sarah Schaeffer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. 218-14-3973A		17. INFORMANT Mr. Philip J. Spampinato		Address Balto 7, Md 3721 Buckingham Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive C.V. disease, severe, DUE TO De Renal Transficiency (c) 20 years							INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL 1949 , to Sept 9, 1958 , that I last saw the deceased alive on Sept 8, 1958 , and that death occurred at 7:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas E. Wheeler M.D.				ADDRESS (Street, city or town, state) Randallstown Md		DATE SIGNED 9-10-58	
PHYSICIAN'S NAME (Type) Dr. Thomas E. Wheeler 3601 Olifmar Road Randallstown, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 9-12-1958		22c. NAME OF CEMETERY OR CREMATORY Reformed Church Cemetery		22d. LOCATION (City, town, or county) (State) Manchester, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byers Linn Hone				ADDRESS 8728 Liberty Road		24a. REC'D BY REGISTRAR SEP 16 '58	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED CHARLES T. HENRY</p>		<p>2. SEX MALE</p>		<p>3. AGE 34</p>		<p>4. DATE OF BIRTH NOV 15 1905</p>		<p>5. PLACE OF BIRTH NEW YORK</p>	
<p>6. OCCUPATION ENGINEER</p>		<p>7. MARITAL STATUS SINGLE</p>		<p>8. COLOR WHITE</p>		<p>9. HEIGHT 5' 10"</p>		<p>10. WEIGHT 175</p>	
<p>11. CAUSE OF DEATH HEART DISEASE</p>		<p>12. PLACE OF DEATH NEW YORK</p>		<p>13. DATE OF DEATH NOV 15 1939</p>		<p>14. TIME OF DEATH 10:30 AM</p>		<p>15. SIGNATURE OF DECEASED CHARLES T. HENRY</p>	
<p>16. SIGNATURE OF WITNESS J. HENRY</p>		<p>17. SIGNATURE OF DECEASED CHARLES T. HENRY</p>		<p>18. SIGNATURE OF WITNESS J. HENRY</p>		<p>19. SIGNATURE OF DECEASED CHARLES T. HENRY</p>		<p>20. SIGNATURE OF WITNESS J. HENRY</p>	
<p>21. SIGNATURE OF DECEASED CHARLES T. HENRY</p>		<p>22. SIGNATURE OF WITNESS J. HENRY</p>		<p>23. SIGNATURE OF DECEASED CHARLES T. HENRY</p>		<p>24. SIGNATURE OF WITNESS J. HENRY</p>		<p>25. SIGNATURE OF DECEASED CHARLES T. HENRY</p>	
<p>26. SIGNATURE OF WITNESS J. HENRY</p>		<p>27. SIGNATURE OF DECEASED CHARLES T. HENRY</p>		<p>28. SIGNATURE OF WITNESS J. HENRY</p>		<p>29. SIGNATURE OF DECEASED CHARLES T. HENRY</p>		<p>30. SIGNATURE OF WITNESS J. HENRY</p>	
<p>31. SIGNATURE OF DECEASED CHARLES T. HENRY</p>		<p>32. SIGNATURE OF WITNESS J. HENRY</p>		<p>33. SIGNATURE OF DECEASED CHARLES T. HENRY</p>		<p>34. SIGNATURE OF WITNESS J. HENRY</p>		<p>35. SIGNATURE OF DECEASED CHARLES T. HENRY</p>	
<p>36. SIGNATURE OF WITNESS J. HENRY</p>		<p>37. SIGNATURE OF DECEASED CHARLES T. HENRY</p>		<p>38. SIGNATURE OF WITNESS J. HENRY</p>		<p>39. SIGNATURE OF DECEASED CHARLES T. HENRY</p>		<p>40. SIGNATURE OF WITNESS J. HENRY</p>	
<p>41. SIGNATURE OF DECEASED CHARLES T. HENRY</p>		<p>42. SIGNATURE OF WITNESS J. HENRY</p>		<p>43. SIGNATURE OF DECEASED CHARLES T. HENRY</p>		<p>44. SIGNATURE OF WITNESS J. HENRY</p>		<p>45. SIGNATURE OF DECEASED CHARLES T. HENRY</p>	
<p>46. SIGNATURE OF WITNESS J. HENRY</p>		<p>47. SIGNATURE OF DECEASED CHARLES T. HENRY</p>		<p>48. SIGNATURE OF WITNESS J. HENRY</p>		<p>49. SIGNATURE OF DECEASED CHARLES T. HENRY</p>		<p>50. SIGNATURE OF WITNESS J. HENRY</p>	

9832

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN lb Dundalk 53	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7446 Berkshire Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Carroll Middle Bonnett Last Lane		4. DATE OF DEATH Month September Day 18 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22, 1919
9. AGE (in years last birthday) 39 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sup.		10b. KIND OF BUSINESS OR INDUSTRY Morris Adv. Co.	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles E. Lane		14. MOTHER'S MAIDEN NAME Dorothy Mueller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 217 05 4699	
17. INFORMANT Mrs. Virginia Lane		Address 7446 Berkshire Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M. B. Davis		DATE SIGNED 9/19/58	
EXAMINER'S NAME (Type) M. B. Davis MD		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 22/58	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore 29, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors 4101 Edmondson Ave		24a. REC'D BY REGISTRAR DATE SEP 24 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Charles A. Lane		Male		White	
Residence		Date of Death		Place of Death	
1405 North 1st St., Baltimore, Md.		Jan. 15, 1925		Baltimore, Md.	
Cause of Death		Manner of Death		Occupation	
Heart Disease		Natural		None	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Date of Report		Time of Report		Place of Report	
Jan. 16, 1925		10:00 AM		Baltimore, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9918

CERTIFICATE OF DEATH

09906

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena 02X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				d. STREET ADDRESS Oakland Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elsie Middle Patricia Last Lipscomb				4. DATE OF DEATH Month Sept. Day 5 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/7/29	
9. AGE (In years last birthday) 28 3/4 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William J. O'Neill				14. MOTHER'S MAIDEN NAME Mary Gardner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-26-0234		17. INFORMANT Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH 1 year			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/26 , 19 58 , to 9/5 , 19 58 , that I last saw the deceased alive on 9/5 , 19 58 , and that death occurred at 4:05 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED 9/5/58							
ACTUAL SIGNATURE William Newcomer M.D.				DATE SIGNED 9/5/58			
PHYSICIAN'S NAME (Type) William Newcomer, M.D.				Superintendent			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-8-58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem		22d. LOCATION (City, town, or county) (State) Brooklyn, Md	
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes				ADDRESS 130 E. Fort Ave.		24a. REC'D BY REGISTRAR DATE SEP 8 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. House			

CERTIFICATE OF DEATH

STATE OF NEW YORK

County of _____

City of _____

State of _____

Decedent's Name _____

Age _____

Sex _____

Married _____

Occupation _____

Place of Birth _____

Date of Birth _____

Place of Death _____

Time of Death _____

Cause of Death _____

Signature of Physician _____

Signature of Coroner _____

Signature of Registrar _____

9919

CERTIFICATE OF DEATH

09907

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 28 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE C MACLIN, JR.				4. DATE OF DEATH Month Day Year September 11 19 58			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 27, 1917		9. AGE (In years last birthday) 41 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor				10b. KIND OF BUSINESS OR INDUSTRY Retail Clothing Store Petersburg, Virginia		11. BIRTHPLACE (State or foreign country) U. S. A	
13. FATHER'S NAME George C. Maclin				14. MOTHER'S MAIDEN NAME Willie Mae Armstead			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II				16. SOCIAL SECURITY NO. 226-07-7742			
17. INFORMANT Clin. Rec., Vet. Adm. Hosp., Ft Howard, Maryland				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE FLOOR OF MOUTH WITH METASTASES DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 143X DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 10 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Petersburg, Va.				20g. (County) Petersburg, Va.		20h. (State) Petersburg, Va.	
21. I certify that I attended the deceased from August 14, 19 58 , to September 11 19 58 , and that death occurred at 2:20 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Petersburg, Va. DATE SIGNED 9/12/58							
ACTUAL SIGNATURE Chien Wei Lan M.D.				PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal				22b. DATE THEREOF 9-17-58		22c. NAME OF CEMETERY OR CREMATORY Eastview Cemetery	
22d. LOCATION (City, town, or county) Petersburg, Va.				22e. (State) Petersburg, Va.		22f. (County) Petersburg, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips				24a. REGISTERED BY REGISTRAR SEP 16 58		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
DATE OF BIRTH [REDACTED]		PLACE OF BIRTH [REDACTED]		RACE [REDACTED]	
DATE OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]		CAUSE OF DEATH [REDACTED]	
TIME OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		MEDICAL HISTORY [REDACTED]	
OCCUPATION [REDACTED]		EDUCATION [REDACTED]		SOCIAL HISTORY [REDACTED]	
MARITAL STATUS [REDACTED]		RELIGION [REDACTED]		SIGNATURE OF DECEASED [REDACTED]	
SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF PHYSICIAN [REDACTED]		SIGNATURE OF CORONER [REDACTED]	
SIGNATURE OF JUDGE [REDACTED]		SIGNATURE OF CLERK [REDACTED]		SIGNATURE OF NOTARY [REDACTED]	

9920

Item 8 FilmG233 9-18-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8 Back River Neck Road				d. STREET ADDRESS 8 Back River Neck Road			
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Marcin, Sr.				4. DATE OF DEATH Month Day Year Sept. 6 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1863 Dec. 22, 1864	9. AGE (In years lost birthday) 94 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Lithuania		11. BIRTHPLACE (State or foreign country) USA		
13. FATHER'S NAME George Marcin			14. MOTHER'S MAIDEN NAME Eva ?				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Address Thomas G. Marcin, Jr.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Anteriorclerotic Cardiovascular disease DUE TO (b) 16 days DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 904.0 Fracture right hip; cystitis; senility							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Fell at home			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I of Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. 9 - 9-21-58			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		
			20f. (City or town) (County) (State) Bolts - 21, Ind.				
21. I certify that I attended the deceased from Aug 21, 1958 , to Sept 6, 1958 , that I last saw the deceased alive on Aug 31, 1958 , and that death occurred at 8:45 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE A. Andrew Alice, M.D.				ADDRESS (Street, city or town, state) DATE SIGNED 1123 St. Paul St.			
PHYSICIAN'S NAME (Type) A. Andrew Alice, M.D.				Bolts - 2, Ind.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 9, 1958		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John A. Grelliauckas Jr.				24a. REC'D BY REGISTRAR 10 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Krome	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9921

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks (rural)				c. LENGTH OF STAY IN Tb life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last Elva Mary McFatridge				4. DATE OF DEATH Month Day Year 9-27-58 19			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-11-1886	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Christopher C. Hooper				14. MOTHER'S MAIDEN NAME Mary Orem			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Frank Kubik		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c) Atherosclerosis						INTERVAL BETWEEN ONSET AND DEATH 11 days years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-26-58 to 9-27-58 , that I last saw the deceased alive on 9-26-58 , and that death occurred at 2:45 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED James G. Saffell M.D. Reisterstown Md 9-27-58 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-30-58		22c. NAME OF CEMETERY OR CREMATORY Immanuel Episcopal		22d. LOCATION (City, town, or county) (State) Glencoe, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Scott Brooks				ADDRESS 622 York Rd., Towson 4, Md.		24a. REC'D BY REGISTRAR DATE OCT 2 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Project: [illegible]
Client: [illegible]
Contract: [illegible]

Project: [illegible]
Client: [illegible]
Contract: [illegible]
Project: [illegible]
Client: [illegible]
Contract: [illegible]

[Large block of illegible text, likely a detailed description of work or terms of service]

Project: [illegible]
Client: [illegible]
Contract: [illegible]
Project: [illegible]
Client: [illegible]
Contract: [illegible]

CERTIFICATE OF DEATH

Reg. Dist. No. **11034**

9022

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 48 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 641 W. Franklin Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOHN C. MEADOWS			4. DATE OF DEATH Month Day Year September 30 1958				
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1900		9. AGE (In years last birthday) yrs. 58		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction Work		11. BIRTHPLACE (State or foreign country) Arkansas			
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME John Meadows				
14. MOTHER'S MAIDEN NAME Ella Hicks			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I				
16. SOCIAL SECURITY NO. 578-01-1027			17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA, RIGHT UPPER LOBE, WITH 162.1 GENERALIZED METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from August 13, 1958 to September 30, 1958 and that death occurred at 8:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland DATE SIGNED 10/1/58 ACTUAL SIGNATURE Chien Wei Lan M.D. VAH, Fort Howard, Maryland PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-6-1958		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.			
22d. LOCATION (City, town, or county) Baltimore, Maryland		22e. (State) Maryland		22f. (City, town, or county) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips		24a. REC'D BY REGISTRAR DATE OCT 8 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9923

CERTIFICATE OF DEATH

09910

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6 Sam Will Avenue		d. STREET ADDRESS 16 Sam Will Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DORA Middle MOWBRY Last MERRYMAN		4. DATE OF DEATH Month September Day 2 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1889
9. AGE (In years last birthday) 69 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Thomas Stains		14. MOTHER'S MAIDEN NAME Mary Katherine Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Charles A. Merryman, Timonium, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF CERVIX 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 YEAR			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 19 56 , to Sept 2 19 58 , that I last saw the deceased alive on Sept. 1 19 58 , and that death occurred at 11:30 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE William A. Pillsbury M.D. ADDRESS (Street, city or town, state) TIMONIUM, MD. DATE SIGNED 9/4/58 PHYSICIAN'S NAME (Type) WILLIAM A. PILLSBURY			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 5, 1958	
22c. NAME OF CEMETERY OR CREMATORY MAYS CHAPEL CEM.		22d. LOCATION (City, town, or county) (State) TIMONIUM, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		24a. REC'D BY REGISTRAR SEP 9 '58	
24b. REGISTRAR'S SIGNATURE Anthony S. Howard			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

<p>1. Name of Deceased: <u>JOHN A. SMITH</u></p>	
<p>2. Date of Death: <u>1945</u></p>	
<p>3. Place of Death: <u>Home</u></p>	
<p>4. Age: <u>45</u></p>	
<p>5. Sex: <u>Male</u></p>	
<p>6. Race: <u>White</u></p>	
<p>7. Cause of Death: <u>Heart Disease</u></p>	
<p>8. Date of Birth: <u>1900</u></p>	
<p>9. Place of Birth: <u>USA</u></p>	
<p>10. Signature of Doctor: <u>[Signature]</u></p>	
<p>11. Signature of Registrar: <u>[Signature]</u></p>	
<p>12. Date of Registration: <u>1945</u></p>	
<p>13. Place of Registration: <u>Baltimore</u></p>	
<p>14. Name of Registrar: <u>[Name]</u></p>	
<p>15. Address of Registrar: <u>[Address]</u></p>	
<p>16. Telephone Number: <u>[Number]</u></p>	
<p>17. Name of Hospital: <u>[Name]</u></p>	
<p>18. Address of Hospital: <u>[Address]</u></p>	
<p>19. Telephone Number: <u>[Number]</u></p>	
<p>20. Name of Physician: <u>[Name]</u></p>	
<p>21. Address of Physician: <u>[Address]</u></p>	
<p>22. Telephone Number: <u>[Number]</u></p>	
<p>23. Name of Coroner: <u>[Name]</u></p>	
<p>24. Address of Coroner: <u>[Address]</u></p>	
<p>25. Telephone Number: <u>[Number]</u></p>	
<p>26. Name of Undertaker: <u>[Name]</u></p>	
<p>27. Address of Undertaker: <u>[Address]</u></p>	
<p>28. Telephone Number: <u>[Number]</u></p>	
<p>29. Name of Burial Place: <u>[Name]</u></p>	
<p>30. Address of Burial Place: <u>[Address]</u></p>	
<p>31. Telephone Number: <u>[Number]</u></p>	
<p>32. Name of Cemetery: <u>[Name]</u></p>	
<p>33. Address of Cemetery: <u>[Address]</u></p>	
<p>34. Telephone Number: <u>[Number]</u></p>	
<p>35. Name of Funeral Home: <u>[Name]</u></p>	
<p>36. Address of Funeral Home: <u>[Address]</u></p>	
<p>37. Telephone Number: <u>[Number]</u></p>	
<p>38. Name of Minister: <u>[Name]</u></p>	
<p>39. Address of Minister: <u>[Address]</u></p>	
<p>40. Telephone Number: <u>[Number]</u></p>	
<p>41. Name of Pastor: <u>[Name]</u></p>	
<p>42. Address of Pastor: <u>[Address]</u></p>	
<p>43. Telephone Number: <u>[Number]</u></p>	
<p>44. Name of Chaplain: <u>[Name]</u></p>	
<p>45. Address of Chaplain: <u>[Address]</u></p>	
<p>46. Telephone Number: <u>[Number]</u></p>	
<p>47. Name of Priest: <u>[Name]</u></p>	
<p>48. Address of Priest: <u>[Address]</u></p>	
<p>49. Telephone Number: <u>[Number]</u></p>	
<p>50. Name of Rabbi: <u>[Name]</u></p>	
<p>51. Address of Rabbi: <u>[Address]</u></p>	
<p>52. Telephone Number: <u>[Number]</u></p>	
<p>53. Name of Imam: <u>[Name]</u></p>	
<p>54. Address of Imam: <u>[Address]</u></p>	
<p>55. Telephone Number: <u>[Number]</u></p>	
<p>56. Name of Minister of Religion: <u>[Name]</u></p>	
<p>57. Address of Minister of Religion: <u>[Address]</u></p>	
<p>58. Telephone Number: <u>[Number]</u></p>	
<p>59. Name of Minister of Religion: <u>[Name]</u></p>	
<p>60. Address of Minister of Religion: <u>[Address]</u></p>	
<p>61. Telephone Number: <u>[Number]</u></p>	
<p>62. Name of Minister of Religion: <u>[Name]</u></p>	
<p>63. Address of Minister of Religion: <u>[Address]</u></p>	
<p>64. Telephone Number: <u>[Number]</u></p>	
<p>65. Name of Minister of Religion: <u>[Name]</u></p>	
<p>66. Address of Minister of Religion: <u>[Address]</u></p>	
<p>67. Telephone Number: <u>[Number]</u></p>	
<p>68. Name of Minister of Religion: <u>[Name]</u></p>	
<p>69. Address of Minister of Religion: <u>[Address]</u></p>	
<p>70. Telephone Number: <u>[Number]</u></p>	
<p>71. Name of Minister of Religion: <u>[Name]</u></p>	
<p>72. Address of Minister of Religion: <u>[Address]</u></p>	
<p>73. Telephone Number: <u>[Number]</u></p>	
<p>74. Name of Minister of Religion: <u>[Name]</u></p>	
<p>75. Address of Minister of Religion: <u>[Address]</u></p>	
<p>76. Telephone Number: <u>[Number]</u></p>	
<p>77. Name of Minister of Religion: <u>[Name]</u></p>	
<p>78. Address of Minister of Religion: <u>[Address]</u></p>	
<p>79. Telephone Number: <u>[Number]</u></p>	
<p>80. Name of Minister of Religion: <u>[Name]</u></p>	
<p>81. Address of Minister of Religion: <u>[Address]</u></p>	
<p>82. Telephone Number: <u>[Number]</u></p>	
<p>83. Name of Minister of Religion: <u>[Name]</u></p>	
<p>84. Address of Minister of Religion: <u>[Address]</u></p>	
<p>85. Telephone Number: <u>[Number]</u></p>	
<p>86. Name of Minister of Religion: <u>[Name]</u></p>	
<p>87. Address of Minister of Religion: <u>[Address]</u></p>	
<p>88. Telephone Number: <u>[Number]</u></p>	
<p>89. Name of Minister of Religion: <u>[Name]</u></p>	
<p>90. Address of Minister of Religion: <u>[Address]</u></p>	
<p>91. Telephone Number: <u>[Number]</u></p>	
<p>92. Name of Minister of Religion: <u>[Name]</u></p>	
<p>93. Address of Minister of Religion: <u>[Address]</u></p>	
<p>94. Telephone Number: <u>[Number]</u></p>	
<p>95. Name of Minister of Religion: <u>[Name]</u></p>	
<p>96. Address of Minister of Religion: <u>[Address]</u></p>	
<p>97. Telephone Number: <u>[Number]</u></p>	
<p>98. Name of Minister of Religion: <u>[Name]</u></p>	
<p>99. Address of Minister of Religion: <u>[Address]</u></p>	
<p>100. Telephone Number: <u>[Number]</u></p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE

9924

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DC b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN 1b Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Manor Rest Home		d. STREET ADDRESS Shoreham Hotel	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle BRANDT Last MICHAEL		4. DATE OF DEATH Month September Day 11 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 12, 1876
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Levi Brandt		14. MOTHER'S MAIDEN NAME Almira Anne Bailey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Stoken Adams Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Sclerotic Heart Disease DUE TO (c) Old Age			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb , 1955 to Sept 11 , 1958, that I last saw the deceased alive on Sept 10 , 1958, and that death occurred at 9 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Walter A. Bailey M.D.		ADDRESS (Street, city or town, state) 1115 St Paul St Baltimore Md	
PHYSICIAN'S NAME (Type) WALTER A. BAILEY		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF Sept. 11, 1958	22c. NAME OF CEMETERY OR CREMATORY Wallis Funeral Home	22d. LOCATION (City, town, or county) (State) Muncy, Penna.
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		24a. REC'D BY REGISTRAR DATE SEP 15 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 6234 9/20/58

09912

9925

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Md</u> c. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Likesville</u>		c. LENGTH OF STAY IN 1b <u>3001-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>(Prof. House) 73 Slade Ave</u>		d. STREET ADDRESS <u>3801 Glengyle Ave</u>	
3. NAME OF DECEASED (Type or print) <u>ANNIE</u> First <u>MICHELSON</u> Middle <u>LOST</u> Last		4. DATE OF DEATH <u>9-14-1958</u> Month <u>9</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1889</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>6</u> Days <u>9</u> Hours <u>14</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Latvia</u>	
11. BIRTHPLACE (State or foreign country) <u>Latvia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Eitel Dagold</u>		14. MOTHER'S MAIDEN NAME <u>Sarah</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1-1-1-1-1-1-1-1-1-1</u>	
17. INFORMANT <u>Mrs. Shirley Sugar - Same</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma - abdominal</u> <u>199.2</u> DUE TO <u>metastatic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 14, 1958</u> to <u>Sept 14, 1958</u> , that I last saw the deceased alive on <u>Sept 14, 1958</u> , and that death occurred at <u>1</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>N. G. Neale</u>		DATE SIGNED <u>9/16/58</u>	
PHYSICIAN'S NAME (Type) <u>N.E. NEEDLE, M.D.</u>		ADDRESS (Street, city or town, state) <u>4215 Park Hgts Ave</u>	
22a. BURIAL, CREMATION, REMOVAL <u>Burial</u>		22b. DATE THEREOF <u>9-17-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Herring Run</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u>		ADDRESS <u>2100 Canton Place</u>	
24a. REC'D BY REGISTRAR <u>SEP 16 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9926

CERTIFICATE OF DEATH

Reg. Dist. No.

09913

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Randallstown</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Richard William Mielke</u>		4. DATE OF DEATH <u>Sept. 7</u> 19 <u>58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 17, 1878</u>
9. AGE (In years lost birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>August Mielke</u>		14. MOTHER'S MAIDEN NAME <u>Betha Schaulk</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Annie Mielke</u>		Address <u>Quince Mills, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO <u>Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiovascular Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/7/1958</u> , to <u>9/7/1958</u> , that I last saw the deceased alive on <u>9/7/1958</u> , and that death occurred at <u>2:25 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. E. Martin</u>		ADDRESS (Street, city or town, state) <u>Randallstown, Md</u>	
PHYSICIAN'S NAME (Type) <u>Wm E. Martin</u>		DATE SIGNED <u>RANDALLSTOWN, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>9-10-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ward's Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Liberty Rd. Balt Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u>		ADDRESS <u>Dyersville, Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09914

9927

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shawman</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shawman Millers</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>✓</u>		d. STREET ADDRESS <u>06 X - 2</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Maurice E Miller</u>		4. DATE OF DEATH Month Day Year <u>September 8 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-24-1916</u>
9. AGE (In years last birthday) <u>41</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Maurice Miller Sr</u>		14. MOTHER'S MAIDEN NAME <u>Edna Ebaugh</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-10-6834</u>	
17. INFORMANT <u>Mrs Maurice Miller - Miller Rd</u>		Address	
18. CAUSE OF DEATH [Enter only one cause pertinent for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Crushing Injury of Skull</u> <u>816 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Injury & Death result of Auto Accident - Head on</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>With Deceased in front of truck turning over on skull.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>5</u> p. m. <u>9/8</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>		20f. City or town (County) (State) <u>Cockeysville Balto Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles F O'Donnell</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles F O'Donnell M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-11-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Manchester</u>		22d. LOCATION (City, town, or county) (State) <u>Cannell as Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E Tipton, Hampstead Md</u>		24a. REC'D BY REGISTRAR <u>SEP 15 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knud</u>	

WESTLAND STATE DEPARTMENT OF HEALTH - BIRMINGHAM 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>	SEX <i>Male</i>
DATE OF DEATH <i>Jan 15 1924</i>		TIME OF DEATH <i>10:30 AM</i>	PLACE OF DEATH <i>Home</i>
CAUSE OF DEATH <i>Myocardial Infarction</i>		MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF EXAMINER <i>Dr. J. H. Smith</i>			
DATE OF EXAMINATION <i>Jan 15 1924</i>			
PLACE OF EXAMINATION <i>Home</i>			
SIGNATURE OF WITNESS <i>John Doe</i>			
DATE OF SIGNATURE <i>Jan 15 1924</i>			
PLACE OF SIGNATURE <i>Home</i>			
SIGNATURE OF SECOND WITNESS <i>John Doe</i>			
DATE OF SIGNATURE <i>Jan 15 1924</i>			
PLACE OF SIGNATURE <i>Home</i>			
SIGNATURE OF THIRD WITNESS <i>John Doe</i>			
DATE OF SIGNATURE <i>Jan 15 1924</i>			
PLACE OF SIGNATURE <i>Home</i>			
SIGNATURE OF FOURTH WITNESS <i>John Doe</i>			
DATE OF SIGNATURE <i>Jan 15 1924</i>			
PLACE OF SIGNATURE <i>Home</i>			
SIGNATURE OF FIFTH WITNESS <i>John Doe</i>			
DATE OF SIGNATURE <i>Jan 15 1924</i>			
PLACE OF SIGNATURE <i>Home</i>			
SIGNATURE OF SIXTH WITNESS <i>John Doe</i>			
DATE OF SIGNATURE <i>Jan 15 1924</i>			
PLACE OF SIGNATURE <i>Home</i>			
SIGNATURE OF SEVENTH WITNESS <i>John Doe</i>			
DATE OF SIGNATURE <i>Jan 15 1924</i>			
PLACE OF SIGNATURE <i>Home</i>			
SIGNATURE OF EIGHTH WITNESS <i>John Doe</i>			
DATE OF SIGNATURE <i>Jan 15 1924</i>			
PLACE OF SIGNATURE <i>Home</i>			
SIGNATURE OF NINTH WITNESS <i>John Doe</i>			
DATE OF SIGNATURE <i>Jan 15 1924</i>			
PLACE OF SIGNATURE <i>Home</i>			
SIGNATURE OF TENTH WITNESS <i>John Doe</i>			
DATE OF SIGNATURE <i>Jan 15 1924</i>			
PLACE OF SIGNATURE <i>Home</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film 233 9-15-58 et

09915

CERTIFICATE OF DEATH

9928

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE RIVER</u>		c. LENGTH OF STAY IN 1b <u>60 YRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) (Daughter's home) <u>2238 HAWTHORNE RD.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton Md.</u> <u>02X-2</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS <u>Et. Meade Bl. Odenton Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Milwicz</u> Last		4. DATE OF DEATH Month <u>Sept.</u> Day <u>6</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/5/1878</u>
9. AGE (In years lost birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Poland</u>	
13. FATHER'S NAME <u>Michael</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Severn Md</u> Address <u>Joseph Milwicz 7 Washington Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease, congestive failure, myocardial infarction</u> 4200 DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u> </u> (b) <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour 20 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>Empyema, left, post-pneumonia, drained.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 15, 1958</u> , to <u>Sept 6, 1958</u> , that I last saw the deceased alive on <u>Sept 4, 1958</u> , and that death occurred at <u>3:45 PM</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>1101 N. CALVERT ST. BALTO-2, MD</u>	
ACTUAL SIGNATURE <u>H. F. Klinefelter</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>DR. H. F. KLINEFELTER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/10/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Co Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Heber</u> ADDRESS <u>401 S. Chester St.</u>		24a. REC'D BY REGISTRAR <u>SEP 8 1958</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09916

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9929

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 12yr3mth19dys		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 1315 Hilman Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle H. Last Moffet		4. DATE OF DEATH Month Sept Day 12 Year 19 58		5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 1, 1878		9. AGE (In years last birthday) 80 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Edward Moffett		14. MOTHER'S MAIDEN NAME Lizzie Remington		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 936.7 DUE TO Acute Cordear failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease (c) Accidental fracture of hip		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) On 7-19-58 pt. was pushed down by another patient, sustaining frac. of neck of rt. Femur.	
20c. TIME OF INJURY Hour 4:00 p. m. Month, Day, Year 7-19-58,		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) Catonsville 28, Md.		20g. (County)		20h. (State)		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE George M. Kieffer, M. D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Sept. 13 58		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 16/58	
22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel		22d. LOCATION (City, town, or county) Baltimore		22e. (State)		23. FUNERAL DIRECTOR'S SIGNATURE Puter Wiedefeld		ADDRESS Biddle St.		24a. REC'D BY REGISTRAR SEP 16 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09917

9930

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 TOWSON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 104 E. PENNA. AVE.		d. STREET ADDRESS 104 E. PENNSYLVANIA AVENUE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BESSIE Middle MORRIS Last		4. DATE OF DEATH Month SEPTEMBER Day 27 Year 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 10, 1958
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM SCHUHART		14. MOTHER'S MAIDEN NAME MARGARET WENNER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT FAMILY RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CEREBRAL ARTERIO SCLEROSIS AND DUE TO HYPERTENSION (c) INTERVAL BETWEEN ONSET OF DEATH 2 HOURS YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MILD DIABETES MELLITUS 260x 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/11 , 19 57 , to 9/27 , 19 58 , that I last saw the deceased alive on 9/27 , 19 58 , and that death occurred at 11:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 25 W. Pa. Ave DATE SIGNED 9/29/58 ACTUAL SIGNATURE Donald L. Somerville M.D. PHYSICIAN'S NAME (Type) Donald L. Somerville M.D. Towson 4, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/30/58	
22c. NAME OF CEMETERY OR CREMATORY PROSPECT HILL CEMETERY		22d. LOCATION (City, town, or county) (State) TOWSON MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN BURNS SONS		24a. REC'D BY REGISTRAR SEP 30 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9931

CERTIFICATE OF DEATH

Reg. Dist. No.

09918

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenarm Road				d. STREET ADDRESS Glenarm Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sister Mary Macaria Mueller Middle Last 				4. DATE OF DEATH Month Sept. Day 24 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 27, 1872	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 		IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY RELIGIOUS.		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph MUELLER				14. MOTHER'S MAIDEN NAME Mary Fritz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 		16. SOCIAL SECURITY NO. 		17. INFORMANT Sister M. Peter Fourier		Address Notch Cliff, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Analyzed Arteriosclerosis 10 yrs. DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 52 , to September , 19 58 , that I last saw the deceased alive on Sept. 16th , 19 58 , and that death occurred at 9:40 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles F. O'Donnell		ADDRESS (Street, city or town, state) DATE SIGNED 7501 York Road Towson 4, Md. 9/24/58					
PHYSICIAN'S NAME (Type) Charles F. O'Donnell M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-26-58		22c. NAME OF CEMETERY OR CREMATORY VILLA MARIA CEM.		22d. LOCATION (City, town, or county) (State) NOTCH CLIFF NR TOWSON, MD	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Zeller				ADDRESS 9015 CONKLING ST BALTO, 24, MD.		24a. REC'D BY REGISTRAR SEP 29 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. Evans			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9932 CERTIFICATE OF DEATH

09919

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dundalk, Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balt.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk Maryland		d. STREET ADDRESS 1901 Agusta Ave	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1901 Agusta Ave		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph Frank Murawski		4. DATE OF DEATH Month 9 Day 3 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-13-1886
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tank Worker		10b. KIND OF BUSINESS OR INDUSTRY Copper Works	
11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Murawski		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-03-0938	
17. INFORMANT Sophia Murawski		Address 1901 Augusta Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CA. P. PANCREAS 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Lung Cancer DUE TO (c) Abdominal Melanoma		INTERVAL BETWEEN ONSET AND DEATH 201X MGS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None			
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 58 , to Apr 3 , 19 58 , that I last saw the deceased alive on Aug. 29 , 19 58 , and that death occurred at 2:45 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE M. B. Davis		DATE SIGNED 6800 Morningstar Rd 9/9/58	
PHYSICIAN'S NAME (Type) M. B. Davis M.D.		Divine - D.M.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-6-1958	22c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary	22d. LOCATION (City, town, or county) (State) Baltimore Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Walter Labrowski		ADDRESS 1001 Dundalk Ave.	
24a. REC'D BY REGISTRAR DATE SEP 5 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Krasa	

CERTIFICATE OF DEATH

1938

Registration No.

DATE OF DEATH

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

DIAGNOSIS

DATE OF EXAMINATION

PLACE OF EXAMINATION

NAME OF PHYSICIAN

SIGNATURE OF PHYSICIAN

DATE OF SIGNATURE

PLACE OF SIGNATURE

NAME OF REGISTRAR

SIGNATURE OF REGISTRAR

DATE OF SIGNATURE

PLACE OF SIGNATURE

NAME OF WITNESS

SIGNATURE OF WITNESS

9933

CERTIFICATE OF DEATH

09920

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>3V01-4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stella Maris Hospice</u>		d. STREET ADDRESS <u>St James Hotel</u>	
3. NAME OF DECEASED (Type or print) First <u>Ellen</u> Middle <u>Teresa</u> Last <u>Murphy</u>		4. DATE OF DEATH Month <u>9</u> Day <u>24</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/25/1899</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel McCarthey</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth McCarthey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>315-03-3439</u>	
17. INFORMANT Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Hypertensive Cardio</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Renal Vascular Disease</u> DUE TO (c) <u>10710</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 10, 1956</u> to <u>Sept 24, 1958</u> , that I last saw the deceased alive on <u>September 24, 1958</u> , and that death occurred at <u>12:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		ADDRESS (Street, city or town, state) <u>7501 York Rd</u> DATE SIGNED <u>9/24/58</u>	
PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell</u>		<u>Towson Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>9-26-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24. REGISTRAR'S SIGNATURE <u>SEP 26 '58</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

09921

CERTIFICATE OF DEATH

Reg. Dist. No.

9934

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 52 Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Recedo Knoll		d. STREET ADDRESS Recedo Knoll-Maiden Choice	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Sister Mary Ann Murtaugh		4. DATE OF DEATH Month Sept. Day 19 Year 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH May 1884
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 74 Days 74 Hours 74 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sister		10b. KIND OF BUSINESS OR INDUSTRY Religious	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Not Known		14. MOTHER'S MAIDEN NAME Not Known	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. --	
17. INFORMANT Sister Cecilia - Recedo Knoll		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardio vascular I. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senile psychosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile psychosis			
INTERVAL BETWEEN ONSET AND DEATH 2 yrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 17 , 19 58 to Sept 19 , 19 58 , that I last saw the deceased alive on 19 , and that death occurred at 5:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 715 Frederick Rd. 28, Md. DATE SIGNED SEP 23 58			
ACTUAL SIGNATURE James E. Rowe		PHYSICIAN'S NAME (Type) James E. Rowe M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-22-58	
22c. NAME OF CEMETERY OR CREMATORY Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home		24a. REG'D BY REGISTRAR SEP 23 58	
ADDRESS Catonsville, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		45		M		W		JAN 15 1918		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTRATION NO.	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		1234		5678	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		SINGLE		MARRIED	
JAN 1 1873		BALTIMORE, MD.		HIGH SCHOOL		MAY 1 1905		YES		NO	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S RESIDENCE		MOTHER'S RESIDENCE	
JAMES H. HARRIS		MARY J. HARRIS		LABORER		HOUSEWIFE		1234 E. BALTIMORE ST.		1234 E. BALTIMORE ST.	
FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH	
FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		FATHER'S EDUCATION		MOTHER'S EDUCATION		FATHER'S MARRIAGE		MOTHER'S MARRIAGE	
								YES		NO	
FATHER'S RESIDENCE		MOTHER'S RESIDENCE		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S RESIDENCE		MOTHER'S RESIDENCE	
1234 E. BALTIMORE ST.		1234 E. BALTIMORE ST.		LABORER		HOUSEWIFE		1234 E. BALTIMORE ST.		1234 E. BALTIMORE ST.	
FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH	
FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		FATHER'S EDUCATION		MOTHER'S EDUCATION		FATHER'S MARRIAGE		MOTHER'S MARRIAGE	
								YES		NO	
FATHER'S RESIDENCE		MOTHER'S RESIDENCE		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S RESIDENCE		MOTHER'S RESIDENCE	
1234 E. BALTIMORE ST.		1234 E. BALTIMORE ST.		LABORER		HOUSEWIFE		1234 E. BALTIMORE ST.		1234 E. BALTIMORE ST.	



9935

CERTIFICATE OF DEATH

09922

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>			
c. LENGTH OF STAY IN 1b <u>31 days</u>				d. STREET ADDRESS <u>Todd Avenue</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HEARDMAN</u> Middle <u>H.</u> Last <u>MUTH</u>				4. DATE OF DEATH Month <u>September</u> Day <u>28</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/18/95</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Counterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Frederick Muth</u>				14. MOTHER'S MAIDEN NAME <u>Mary Herman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>VW I</u>		17. INFORMANT <u>Clin. Records, Vets. Adm. Hospital, Ft. Howard, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>VA</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that I attended the deceased from <u>August 28</u> , 19 <u>58</u> , to <u>Sept. 28</u> , 19 <u>58</u> , that I lost care of the deceased <u>time of death</u> , and that death occurred at <u>10:10AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>T. L. Fleisher</u>				ADDRESS (Street, city or town, state) <u>VAH, FORT HOWARD, MARYLAND</u>			
PHYSICIAN'S NAME (Type) <u>T. L. FLEISHER, JR. M.D.</u>				DATE SIGNED <u>VAH, FORT HOWARD, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-1-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight Inc. Baltimore 14, Maryland</u>				24a. REC'D BY REGISTRAR <u>SEP 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. Cook-Blight</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3023

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

PLACE TO BE MADE		DATE	
HOSPITAL		MAY 1963	
A CITY OR TOWN IN WHICH DEATH OCCURRED		BALTIMORE	
COUNTY IN WHICH DEATH OCCURRED		BALTIMORE	
NAME OF DECEASED		JOHN DOE	
SEX		MALE	
AGE		45	
RACE		WHITE	
EDUCATION		HIGH SCHOOL	
OCCUPATION		CLERK	
MANNER OF DEATH		NATURAL	
CAUSE OF DEATH		HEART DISEASE	
IMMEDIATE CAUSE		MYOCARDIAL INFARCTION	
UNDERLYING CAUSE		CORONARY ARTERY DISEASE	
MORBIDITY		NO	
MORTALITY		NO	
SIGNATURE OF PHYSICIAN		[Signature]	
DATE OF SIGNATURE		MAY 1963	
PLACE OF SIGNATURE		BALTIMORE	
NAME OF PHYSICIAN		DR. J. SMITH	
ADDRESS OF PHYSICIAN		123 MAIN ST.	
CITY OF PHYSICIAN		BALTIMORE	
STATE OF PHYSICIAN		MD	
COUNTY OF PHYSICIAN		BALTIMORE	
NAME OF REGISTRAR		[Signature]	
DATE OF SIGNATURE		MAY 1963	
PLACE OF SIGNATURE		BALTIMORE	
NAME OF REGISTRAR		J. DOE	
ADDRESS OF REGISTRAR		456 MAIN ST.	
CITY OF REGISTRAR		BALTIMORE	
STATE OF REGISTRAR		MD	
COUNTY OF REGISTRAR		BALTIMORE	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9936

CERTIFICATE OF DEATH

Reg. Dist. No.

09923

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1mth3dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ruth Middle Russell Last Myers		4. DATE OF DEATH Month September Day 9 Year 19 58	
5. SEX white	6. COLOR OR RACE female	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 2, 1888
9. AGE (In years lost birthday) yrs. 70		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John B. Russell		14. MOTHER'S MAIDEN NAME Henrietta Scott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalized and severe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 6 , 19 58 , to Sept. 9 , 19 58 , that I last saw the deceased alive on Sept. 9 , 19 58 , and that death occurred at 10:00 a. m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Stella Wachslar M.D. SPRING GROVE STATE HOSPITAL 9-9-58 PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 11-58	
22c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemt		22d. LOCATION (City, town, or county), (State) Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Sons		24a. REC'D BY REGISTRAR DATE SEP 15 '58	
ADDRESS Annapolis Md.		24b. REGISTRAR'S SIGNATURE Carlton S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09924

9937

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		c. LENGTH OF STAY IN 1b X Woodlawn	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7107 Windsor Mill Road		d. STREET ADDRESS 7107 Windsor Mill Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MAUDE Middle ROBERTS Last NEWTON		4. DATE OF DEATH Month September Day 2 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 12, 1872
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 86 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John B. Roberts		14. MOTHER'S MAIDEN NAME Mary Ann Burn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	
17. INFORMANT Edward D. Mitchell-231 S. Augusta Ave. 29		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure c DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Infarction x Pulmonary edema 2 days DUE TO Hypertension C.V. disease c lying cause lost. (c) Severe		INTERVAL BETWEEN ONSET AND DEATH 70 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Hypertension		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 Month 19 Day 19 Year 19 o. m. 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1, 1958 , to Sept 2, 1958 , that I last saw the deceased alive on Sept 2, 1958 , and that death occurred at 7 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas E. Wheeler		M.D. 3601 Chpin Rd ADDRESS (Street, city or town, state) Balto Md DATE SIGNED 9/2/58	
PHYSICIAN'S NAME (Type) Thomas E. Wheeler, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/4/1958	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Woodlawn Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		ADDRESS Liberty Hghts. Ave.	
24a. REC'D BY REGISTRAR DATE SEP 5 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH - CERTIFICATE OF DEATH

WILSON
PROVIDENT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9938

CERTIFICATE OF DEATH

09925

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edmondson Heights	c. LENGTH OF STAY IN 1b 4 Mos.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Edmondson Heights (Balto. 7)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1453 Langford Road Balto. 7		d. STREET ADDRESS 1453 Langford Road	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First James Middle Whitaker Last Nickerson		4. DATE OF DEATH Month Sept. Day 27, Year 19 58.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 21, 1888
9. AGE (In years last birthday) yrs. 70		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John R. Nickerson		14. MOTHER'S MAIDEN NAME Anne Hess	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) W.W.1		16. SOCIAL SECURITY NO. 216-01-9899	
17. INFORMANT Mabel A. Nickerson		Address 1453 Langford Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerosis & Cardiac dis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from June 4, 1958 to Sept 27, 1958 that I last saw the deceased alive on Sept 16, 1958 and that death occurred at 5 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE I. EARL PASS		DATE SIGNED 4001 Wilkens Ave 9-29-58 Balto 29 Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-30-1958	
22c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park		22d. LOCATION (City, town, or county) (State) Elkridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G. Howard Strong		24a. REC'D BY REGISTRAR DATE SEP 30 '58	
ADDRESS 3707 W North Ave		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES J. HENRY		SEX Male	
AGE 68		DATE OF BIRTH 1881	
PLACE OF BIRTH Ireland		DATE OF DEATH 1955	
PLACE OF DEATH Boston, Mass.		TIME OF DEATH 10:30 A.M.	
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN J. J. Henry		SIGNATURE OF REGISTRAR J. J. Henry	
SIGNATURE OF WITNESS J. J. Henry		SIGNATURE OF WITNESS J. J. Henry	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9939

Reg. Dist. No. 09926

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Woodlawn</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5003 Gwynndale Ave</u>				d. STREET ADDRESS <u>5003 Gwynndale Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>I.</u> Last <u>Noel</u>				4. DATE OF DEATH Month <u>Sep.</u> Day <u>29</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 4, 1888</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cementor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (State or foreign country) <u>McSherrys, Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Noel</u>				14. MOTHER'S MAIDEN NAME <u>Louisa Kuhn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>212-03-2822</u>		17. INFORMANT <u>David Haag</u> Address <u>5005 Gwynndale Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteio sclerotic Cardiovascular disease</u> (c) <u> </u> DUE TO (a), stating the underlying cause lost. (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> (b) <u> </u> (c) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/2/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth Armacost</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9940

CERTIFICATE OF DEATH

09927

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>at home</u>				d. STREET ADDRESS <u>312 Melancthon Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Evereen Ridgely Messer</u>				4. DATE OF DEATH Month Day Year <u>Sept 10 1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 28 1893</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Month Days Hours Min.		IF UNDER 24 HRS. Month Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance - Mass Mutual</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Lutherville</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Jos S Messer</u>				14. MOTHER'S MAIDEN NAME <u>Clara T. Redaeker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-30-2287</u>		17. INFORMANT <u>M. W. S. Pugh - Tolson</u> Address <u>Belle 4</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u>							
334X DUE TO <u>Arteriosclerosis, gen & cerebral</u>							
(b) DUE TO <u>Uch</u>							
(c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 4</u> , 1958, to <u>Sept 10</u> , 1958, that I last saw the deceased alive on <u>Sept 8</u> , 1958, and that death occurred at <u>100 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bennett A. Stoen</u>				ADDRESS (Street, city or town, state) <u>19 W. Seminary Ave. Lutherville</u> DATE SIGNED <u>9/10/58</u>			
PHYSICIAN'S NAME (Type) <u>BENNETT A. STOEN.</u>				L(<u>19 W. SEMINARY AVE. LUTHERVILLE</u> 9/10/58			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Sept 11</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lutherville</u>		22d. LOCATION (City, town, or county) (State) <u>Belle 30-MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stewart</u> ADDRESS <u>108 W York</u>				24a. REC'D BY REGISTRAR <u>SEP 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

1 FOR ST HEALTH

any, please
-tor. Page
your files.
the State Board of Health,
within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is
execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Folley Farm - Wards Chapel Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Columbus K. Ward Oakley		4. DATE OF DEATH Month Sept. Day 25 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 6. 1898
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney-Executive Sec. Md. Insurance Agents		10b. KIND OF BUSINESS OR INDUSTRY Maryland- Magnolia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas B. Oakley		14. MOTHER'S MAIDEN NAME Laura Jane ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-28-2320	
17. INFORMANT Margarethe S. Oakley		Address Spring Folley Farm Owings Mills, MD	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Coronary Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

Minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a. m. p. m. 19

20d. INJURY OCCURRED
While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒. Inquiry ☐. and in my opinion death resulted from: Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE

Clarence E. McWilliams

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

September 25, 1958

EXAMINER'S NAME (Type)

Dr. Clarence E. McWilliams

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

9/29/58

22c. NAME OF CEMETERY OR CREMATORY

Parkwood Cemetery

22d. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Wm J. Pickner & Sons

ADDRESS

Balto 17, Md

24a. REC'D BY REGISTRAR

SEP 29 '58

24b. REGISTRAR'S SIGNATURE

Arthur S. House

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09929

9942

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ruxton</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Ruxton</u>		d. STREET ADDRESS <u>1 2006 Sky Line Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>M.</u> Last <u>Overbeck</u>				4. DATE OF DEATH Month <u>September</u> Day <u>23</u> Year <u>19 58</u>					
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 23, 1887</u>		9. AGE (In years last birthday) <u>71</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Geologist.</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles Overbeck</u>				14. MOTHER'S MAIDEN NAME <u>Emma Smith</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Wife - 2006 Skyline Rd.</u>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of the stomach.</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month _____ Day _____ Year <u>19</u> Hour o. m. _____ p. m. _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 19____, to <u>Sept 22, 19 58</u> , that I last saw the deceased alive on <u>Sept. 21 -</u> , 19 <u>58</u> , and that death occurred at <u>2 A.</u> M, from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Lessie N. Gay</u>				M.D. <u>1114 St. Paul St.</u>				DATE SIGNED <u>9/23/58</u>	
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/25/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		22d. LOCATION (City, town, or county) _____ (State) _____ <u>Pikesville, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John O. Mitchell & Sons, Inc. 1900 Eutaw Place</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>SEP 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09930

9943

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. LENGTH OF STAY IN 1b <i>55</i> <i>Towson</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1770 Joan Avenue</i>		d. STREET ADDRESS <i>1770 Joan Avenue</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Mr. Harry G.</i> Middle <i>Palmer</i> Last <i>Palmer</i>		4. DATE OF DEATH Month <i>September</i> Day <i>22</i> Year <i>1958</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 24, 1880</i>
9. AGE (In years last birthday) <i>78</i> yrs.		IF UNDER 1 YEAR Months <i>78</i> Days <i>78</i> Hours <i>78</i> Min. <i>78</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Boiler Maker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>P.R.R.</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>George Palmer</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Freeland</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Evelyn M. Taylor, 1770 Joan Ave.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary edema</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>myocardial infarction</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>9/15</i> , 19 <i>57</i> , to <i>9/22</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>9/22</i> , 19 <i>58</i> , and that death occurred at <i>4:30</i> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Gordon Grau</i> M.D.		ADDRESS (Street, city or town, state) <i>8523 Loch Raven Blvd</i> DATE SIGNED <i>9/23/58</i>	
PHYSICIAN'S NAME (Type) <i>Edward Gordon Grau</i>		<i>Baltimore, 4, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9/25/58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Zion Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>	
24a. REC'D BY REGISTRAR DATE <i>SEP 24 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9944

CERTIFICATE OF DEATH

09931

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN lb 55 Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Codd Nursing Home		d. STREET ADDRESS 625 York Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ADDIE MAY PARKS		4. DATE OF DEATH Month Day Year September 5, 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 2, 1879
9. AGE (In years lost birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Samuel E. Parks		14. MOTHER'S MAIDEN NAME Martha Lee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Family Records
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Rectum 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Sept 4 19 58 , to Sept 5 19 58 , that I last saw the deceased alive on Sept 5 19 58 , and that death occurred at 6:50 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 625 York Rd Baltimore 12 Md DATE SIGNED			
ACTUAL SIGNATURE Laurence C Post M.D.			
PHYSICIAN'S NAME (Type) LAURENCE C Post			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 9, 1958	22c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery	22d. LOCATION (City, town, or county) (State) Towson, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		24a. REC'D BY REGISTRAR DATE SEP 9 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kinn			

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

TOWN

COUNTY

AGE

SEX

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

DECEASED'S SIGNATURE

WITNESSES

DECEASED'S ADDRESS

DECEASED'S PHONE

DECEASED'S SOCIAL SECURITY

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 12, Film G234, 10/6/58
9945
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
99932
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eastpoint</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eastpoint</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8038 Nynbrook Avenue</u>		d. STREET ADDRESS <u>18038 Nynbrook Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA JULIA PAZNEK</u>		4. DATE OF DEATH Month Day Year <u>SEPT. 28 1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 31-1894</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>LITHUANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>? MASIS</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>196-18-1917</u>	
17. INFORMANT Address <u>PETER PAZNEK ABOVE (SON)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastases of the lungs</u> DUE TO (c) <u>Cancer of the breast</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 yrs</u> <u>17 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491x Ematation</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 24, 1957</u> to <u>September 27, 1958</u> , that I last saw the deceased alive on <u>September 27, 1958</u> , and that death occurred at <u>8:50 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eugene C. Baumann</u> M.D.		ADDRESS (Street, city or town, state) <u>413 Eastern Ave, Essex 21, Md.</u>	
DATE SIGNED <u>9-28-58</u>			
PHYSICIAN'S NAME (Type) <u>Eugene C. Baumann</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>9/28/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GRAND VIEW</u>		22d. LOCATION (City, town, or county) (State) <u>CAMBRIDG Co. PA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John S. Connelly Essex</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 1 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4' may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9946

CERTIFICATE OF DEATH

09933

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 16dys	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchville, Maryland		12X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS Churchville, Maryland	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Stephen Middle Edward Last Peery		4. DATE OF DEATH Month September Day 8 Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1886
9. AGE (In years lost birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farming	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Perry		14. MOTHER'S MAIDEN NAME Mary Jane Groseclase	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W. W. I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary thrombosis and infarction 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic nephrosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 26 , 19 58 , to Sept. 8 , 19 58 , that I last saw the deceased alive on Sept. 8 , 19 58 , and that death occurred at 7:10a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachsler		DATE SIGNED SPRING GROVE STATE HOSPITAL 9-8-58	
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/10/58	
22c. NAME OF CEMETERY OR CREMATORY Presbyterian Cemetery		22d. LOCATION (City, town, or county) (State) Churchville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring		ADDRESS Aberdeen, Md.	
24a. REC'D BY REGISTRAR SEP 11 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

9947

CERTIFICATE OF DEATH

09934

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 101 Days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 3V01.4 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1018 Hillman Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RALPH Middle R. Last PERKINS		4. DATE OF DEATH Month September Day 7 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 16, 1881
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer-unemployed		10b. KIND OF BUSINESS OR INDUSTRY Building Service	11. BIRTHPLACE (State or foreign country) Clyde, New York
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Frank Perkins	
14. MOTHER'S MAIDEN NAME Nora Clum		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes 2/15/99-3/17/99	
16. SOCIAL SECURITY NO. 089-09-5241		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MYOCARDIAL INFARCTION DUE TO (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		INTERVAL BETWEEN ONSET AND DEATH 14 HOURS 30 HOURS UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 29 , 19 58 , to September 7 , 19 58 , and that death occurred at 2:05P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE L. Bruce Smith		ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND	
PHYSICIAN'S NAME (Type) L. BRUCE SMITH, M.D.		DATE SIGNED 9/8/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-11-58	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc.		24a. REC'D BY REGISTRAR Wm Cook-Blight, Inc.	
24b. REGISTRAR'S SIGNATURE Wm Cook-Blight, Inc.		24c. DATE 9-11-58	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9833

CERTIFICATE OF DEATH

09935

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. LENGTH OF STAY IN 1b 53 DUNDALK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 24 MARYLAND AVE		d. STREET ADDRESS Box 24 MARYLAND AVE	
3. NAME OF DECEASED (Type or print) First Middle Last EDITH R. PETERSON		4. DATE OF DEATH Month Day Year SEPT 17 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 30 1896
9. AGE (In years lost birthday) yrs. 61		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY ROTHE		14. MOTHER'S MAIDEN NAME HANNAH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. FRED'K PETERSON BOX 24 - MARYLAND AVE	
17. INFORMANT FRED'K PETERSON BOX 24 - MARYLAND AVE		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4 days			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-1 , 19 58 to 9-12 , 19 58 , that I last saw the deceased alive on 9-12 , 19 58 , and that death occurred at 2 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Jack C Collins		ADDRESS (Street, city or town, state) 2 Kinship	
PHYSICIAN'S NAME (Type) JACK C COLLINS		DATE SIGNED 9-13-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT 15 1958	
22c. NAME OF CEMETERY OR CREMATORY CAK LAWN		22d. LOCATION (City, town, or county) (State) COLGATE MD	
23. FUNERAL DIRECTOR'S SIGNATURE WILLRICH FUNERAL HOME - DUNDALK MD		ADDRESS	
24a. REC'D BY REGISTRAR SEP 17 58		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

CERTIFICATE OF DEATH

Page One of Two

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>10/15/1968</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. DATE OF BIRTH <i>10/15/1923</i>		11. SEX OF BIRTH <i>Male</i>		12. AGE AT BIRTH <i>45</i>	
13. DATE OF DEATH <i>10/15/1968</i>		14. TIME OF DEATH <i>10:00 AM</i>		15. PLACE OF DEATH <i>Home</i>	
16. CAUSE OF DEATH <i>Myocardial Infarction</i>		17. MANNER OF DEATH <i>Natural</i>		18. PLACE OF BIRTH <i>Baltimore, Md.</i>	
19. DATE OF BIRTH <i>10/15/1923</i>		20. SEX OF BIRTH <i>Male</i>		21. AGE AT BIRTH <i>45</i>	
22. DATE OF DEATH <i>10/15/1968</i>		23. TIME OF DEATH <i>10:00 AM</i>		24. PLACE OF DEATH <i>Home</i>	
25. CAUSE OF DEATH <i>Myocardial Infarction</i>		26. MANNER OF DEATH <i>Natural</i>		27. PLACE OF BIRTH <i>Baltimore, Md.</i>	
28. DATE OF BIRTH <i>10/15/1923</i>		29. SEX OF BIRTH <i>Male</i>		30. AGE AT BIRTH <i>45</i>	
31. DATE OF DEATH <i>10/15/1968</i>		32. TIME OF DEATH <i>10:00 AM</i>		33. PLACE OF DEATH <i>Home</i>	
34. CAUSE OF DEATH <i>Myocardial Infarction</i>		35. MANNER OF DEATH <i>Natural</i>		36. PLACE OF BIRTH <i>Baltimore, Md.</i>	
37. DATE OF BIRTH <i>10/15/1923</i>		38. SEX OF BIRTH <i>Male</i>		39. AGE AT BIRTH <i>45</i>	
40. DATE OF DEATH <i>10/15/1968</i>		41. TIME OF DEATH <i>10:00 AM</i>		42. PLACE OF DEATH <i>Home</i>	
43. CAUSE OF DEATH <i>Myocardial Infarction</i>		44. MANNER OF DEATH <i>Natural</i>		45. PLACE OF BIRTH <i>Baltimore, Md.</i>	
46. DATE OF BIRTH <i>10/15/1923</i>		47. SEX OF BIRTH <i>Male</i>		48. AGE AT BIRTH <i>45</i>	
49. DATE OF DEATH <i>10/15/1968</i>		50. TIME OF DEATH <i>10:00 AM</i>		51. PLACE OF DEATH <i>Home</i>	
52. CAUSE OF DEATH <i>Myocardial Infarction</i>		53. MANNER OF DEATH <i>Natural</i>		54. PLACE OF BIRTH <i>Baltimore, Md.</i>	
55. DATE OF BIRTH <i>10/15/1923</i>		56. SEX OF BIRTH <i>Male</i>		57. AGE AT BIRTH <i>45</i>	
58. DATE OF DEATH <i>10/15/1968</i>		59. TIME OF DEATH <i>10:00 AM</i>		60. PLACE OF DEATH <i>Home</i>	
61. CAUSE OF DEATH <i>Myocardial Infarction</i>		62. MANNER OF DEATH <i>Natural</i>		63. PLACE OF BIRTH <i>Baltimore, Md.</i>	
64. DATE OF BIRTH <i>10/15/1923</i>		65. SEX OF BIRTH <i>Male</i>		66. AGE AT BIRTH <i>45</i>	
67. DATE OF DEATH <i>10/15/1968</i>		68. TIME OF DEATH <i>10:00 AM</i>		69. PLACE OF DEATH <i>Home</i>	
70. CAUSE OF DEATH <i>Myocardial Infarction</i>		71. MANNER OF DEATH <i>Natural</i>		72. PLACE OF BIRTH <i>Baltimore, Md.</i>	
73. DATE OF BIRTH <i>10/15/1923</i>		74. SEX OF BIRTH <i>Male</i>		75. AGE AT BIRTH <i>45</i>	
76. DATE OF DEATH <i>10/15/1968</i>		77. TIME OF DEATH <i>10:00 AM</i>		78. PLACE OF DEATH <i>Home</i>	
79. CAUSE OF DEATH <i>Myocardial Infarction</i>		80. MANNER OF DEATH <i>Natural</i>		81. PLACE OF BIRTH <i>Baltimore, Md.</i>	
82. DATE OF BIRTH <i>10/15/1923</i>		83. SEX OF BIRTH <i>Male</i>		84. AGE AT BIRTH <i>45</i>	
85. DATE OF DEATH <i>10/15/1968</i>		86. TIME OF DEATH <i>10:00 AM</i>		87. PLACE OF DEATH <i>Home</i>	
88. CAUSE OF DEATH <i>Myocardial Infarction</i>		89. MANNER OF DEATH <i>Natural</i>		90. PLACE OF BIRTH <i>Baltimore, Md.</i>	
91. DATE OF BIRTH <i>10/15/1923</i>		92. SEX OF BIRTH <i>Male</i>		93. AGE AT BIRTH <i>45</i>	
94. DATE OF DEATH <i>10/15/1968</i>		95. TIME OF DEATH <i>10:00 AM</i>		96. PLACE OF DEATH <i>Home</i>	
97. CAUSE OF DEATH <i>Myocardial Infarction</i>		98. MANNER OF DEATH <i>Natural</i>		99. PLACE OF BIRTH <i>Baltimore, Md.</i>	
100. DATE OF BIRTH <i>10/15/1923</i>		101. SEX OF BIRTH <i>Male</i>		102. AGE AT BIRTH <i>45</i>	

103. I hereby certify that the above is a true and correct statement of the facts as stated on the death certificate of the deceased.

104. I hereby certify that the above is a true and correct statement of the facts as stated on the death certificate of the deceased.

105. I hereby certify that the above is a true and correct statement of the facts as stated on the death certificate of the deceased.

106. I hereby certify that the above is a true and correct statement of the facts as stated on the death certificate of the deceased.

107. I hereby certify that the above is a true and correct statement of the facts as stated on the death certificate of the deceased.

108. I hereby certify that the above is a true and correct statement of the facts as stated on the death certificate of the deceased.

109. I hereby certify that the above is a true and correct statement of the facts as stated on the death certificate of the deceased.

110. I hereby certify that the above is a true and correct statement of the facts as stated on the death certificate of the deceased.

111. I hereby certify that the above is a true and correct statement of the facts as stated on the death certificate of the deceased.

112. I hereby certify that the above is a true and correct statement of the facts as stated on the death certificate of the deceased.

113. I hereby certify that the above is a true and correct statement of the facts as stated on the death certificate of the deceased.

114. I hereby certify that the above is a true and correct statement of the facts as stated on the death certificate of the deceased.

115. I hereby certify that the above is a true and correct statement of the facts as stated on the death certificate of the deceased.

116. I hereby certify that the above is a true and correct statement of the facts as stated on the death certificate of the deceased.

117. I hereby certify that the above is a true and correct statement of the facts as stated on the death certificate of the deceased.

118. I hereby certify that the above is a true and correct statement of the facts as stated on the death certificate of the deceased.

119. I hereby certify that the above is a true and correct statement of the facts as stated on the death certificate of the deceased.

120. I hereby certify that the above is a true and correct statement of the facts as stated on the death certificate of the deceased.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9948

Item 1 Film G234 9-29-58 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY a. a.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point				c. LENGTH OF STAY IN 1b 0250.2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethlehem Steel Co.				d. STREET ADDRESS 200 E. Doris Ave.			
3. NAME OF DECEASED (Type or print) First GEORGE Middle G. Last PHELPS				4. DATE OF DEATH Month September Day 17 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1910	9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months 48 Days 17 Hours 1958	IF UNDER 24 HRS. Months 48 Days 17 Hours 1958	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		10b. KIND OF BUSINESS OR INDUSTRY Both Steel Co.		11. BIRTHPLACE (State or foreign country) md.		12. CITIZEN OF WHAT COUNTRY? usa	
13. FATHER'S NAME George W. Phelps				14. MOTHER'S MAIDEN NAME Carrie W. Weaver			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Mrs Evelyn Phelps Address 200 E Doris Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 422.1 DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. 19 p. m.	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Russell S. Fisher, M.D.		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 9/17/58			
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-20-58	22c. NAME OF CEMETERY OR CREMATORY Green Haven		22d. LOCATION (City, town, or county) (State) Green Haven, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes				ADDRESS 130 E Fort Ave		24a. REC'D BY REGISTRAR SEP 19 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. Krawe			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by you. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		45		M		W		JAN 15 1900		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF BURIAL		DATE OF BURIAL	
1234 E. BALTIMORE ST.		CARPENTER		HEART DISEASE		NATURAL		CATHOLIC CHURCH		JAN 16 1900	
PREVIOUS ILLNESS		SYMPTOMS		TREATMENT		POST-MORTEM		SIGNATURE OF EXAMINER		OFFICIAL SEAL	
NONE		PAIN IN CHEST		NONE		NONE		J. H. HARRIS		[Seal]	
DATE OF EXAMINATION		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF MINISTER		SIGNATURE OF CLERGY		SIGNATURE OF JURY	
JAN 15 1900		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9949

CERTIFICATE OF DEATH

09937

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3Y01-4 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Robb Nursing Home</u>		d. STREET ADDRESS <u>425 S. Robinson St.</u>	
3. NAME OF DECEASED (Type or print) <u>Margaret</u> First <u>mini</u> Middle <u>Phillips</u> Last		4. DATE OF DEATH <u>Sept</u> Month <u>27</u> Day <u>19</u> Year <u>58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 24, 1883</u>
9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore</u>	
11. BIRTHPLACE (State or foreign country) <u>K. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>K. S. A.</u>	
13. FATHER'S NAME <u>George Phillips</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Bender</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>MRS ROBERT SNYDER 5362 LIBERTY HTS</u>	
17. INFORMANT <u>MRS ROBERT SNYDER 5362 LIBERTY HTS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Repease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/19</u> 19 <u>58</u> , to <u>9/27</u> 19 <u>58</u> , that I last saw the deceased alive on <u>9/26</u> 19 <u>58</u> , and that death occurred at <u>6:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>P. H. Casville 8</u> DATE SIGNED <u>9/27/58</u>			
ACTUAL SIGNATURE <u>Charles H. Williams</u> M.D.		PHYSICIAN'S NAME (Type) <u>Charles H. Williams</u> <u>1632 Reisterstown Rd</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/1/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN CEMT</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lawrence F. Hoffman</u> ADDRESS <u>3218 Anderson St</u>		24a. REC'D BY REGISTRAR <u>SEP 30 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

VS. A15ME(5)
SM 9/55

1. PLACE OF DEATH a. COUNTY <u>Balto.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto 7.</u>		c. LENGTH OF STAY IN IB <u>11 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3114 Sussex Rd</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto 7</u>	
d. STREET ADDRESS <u>3614 Sussex Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HATTIE GRACE PINDER</u>		4. DATE OF DEATH Month Day Year <u>Sept. 21 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 22, 1899</u>
9. AGE (in years last birthday) <u>59 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>39</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Potomac, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Shipley</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Hunter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>John E. Pinder Jr</u>		Address <u>3614 Sussex Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suicide due to Barbiturate Poisoning 6 hrs.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Mental depression & Psychosis 3-4 yrs.</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260+ Mild Diabetes</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>Sept 21 1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u>none</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State) <u>Balto. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>D. D. Caples</u>		DATE SIGNED <u>Sept 21 '58</u>	
EXAMINER'S NAME (Type) <u>D. D. CAPLES, M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/24/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wood Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byers</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 25 '58</u>	
ADDRESS <u>8728 Liberty Road</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraske</u>	
<u>Randallstown, Md.</u>			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 11
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED

NOV 11 1964

11

11

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9951

CERTIFICATE OF DEATH

09939

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>8 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>600 S. Kenwood</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>T.</u> Last <u>PLEWACKI</u>				4. DATE OF DEATH Month <u>September</u> Day <u>13</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 27, 1898</u>	9. AGE (In years lost birth-day) <u>60</u> yrs.	IF UNDER 1 YEAR Months <u>60</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canning Company</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Plewacki</u>				14. MOTHER'S MAIDEN NAME <u>Praxeda Kowaleski</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>WW I 418-26-0175</u>		17. INFORMANT <u>Clin. Rec. Vet. Adm. Hosp. Ft. Howard, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF THE RIGHT KIDNEY WITH METASTASIS</u> <u>180X</u> <u>TO THE SPINAL CORD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>September 5, 1958</u> to <u>September 13, 1958</u> , and that death occurred at <u>5:55 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Chien Wei Lan</u> M.D. PHYSICIAN'S NAME (Type) <u>CH IEN WEI LAN, M. D.</u> <u>VAH, Fort Howard, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 17 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md. 135 Boston St.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marie Fialkowski Funeral Home</u>				ADDRESS <u>1000 S. Kenwood</u> <u>Baltimore 21, Md</u>		24a. REC'D BY REGISTRAR <u>9/15/58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur J. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9952

CERTIFICATE OF DEATH

09940

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 12 Hours d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 916 North Bond Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First AMOS Middle E. Last PORTER		4. DATE OF DEATH Month September Day 5 Year 1958			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1902	9. AGE (In years last birthday) yrs. 56	IF UNDER 1 YEAR Months 5 Days 15 Hours 4 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Lumber Company		11. BIRTHPLACE (State or foreign country) Anne Arundel County, Md.	
13. FATHER'S NAME Elijah Porter		14. MOTHER'S MAIDEN NAME Adeline Mulberry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II 214-18-7108		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEVERE GASTRO-INTESTINAL HEMORRHAGE, SITE 578 X XXXX UNDETERMINED Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PARKINSON'S DISEASE. DIABETES MELLITUS 260X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PARKINSON'S DISEASE. DIABETES MELLITUS 260X					INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VA	
20f. (City or town) VA		20g. (County) VA			
20h. (State) VA		20i. (State) VA			
21. I certify that I attended the deceased from 11:25 AM 9/5/1958 to 11:25 PM 9/5/1958 and that death occurred at 11:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VA HOSPITAL, FORT HOWARD, MD. DATE SIGNED 9/8/58					
ACTUAL SIGNATURE W. W. Schier M.D. M.D. VA HOSPITAL, FORT HOWARD, MD. DATE SIGNED 9/8/58					
PHYSICIAN'S NAME (Type) W. W. SCHIER, M.D., Chief, Professional Services					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/10/58		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore, Maryland	
22d. LOCATION (City, town, or county) Baltimore, Maryland		22e. (State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Isaiah Brown ADDRESS 108 W. Montgomery St. Baltimore, Maryland					
24a. REC'D BY REGISTRAR SEP 11 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9834

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6743 Roberts Avenue				d. STREET ADDRESS 6743 Roberts Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Frank Middle Ptaszynski Last (Burke)				4. DATE OF DEATH Month September Day 3 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 31, 1908		9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months 49 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marine Machinist		10b. KIND OF BUSINESS OR INDUSTRY Curtis Bay Towing		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexander Ptaszynski				14. MOTHER'S MAIDEN NAME Julia Zaycka			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 317-14-362		17. INFORMANT Jennie Ptaszynski Address 6743 Roberts Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) 420.1 DUE TO (a), stating the underlying cause lost. (c)							INTERVAL BETWEEN ONSET AND DEATH —
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Hour a. m. 19 p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State) None		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M. B. Davis				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Melvin B. Davis, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 6, 1958		22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery		22d. LOCATION (City, town, or county) (State) 6515 Boston St., Maryland?	
23. FUNERAL DIRECTOR'S SIGNATURE Marie Fialkowski				24a. REC'D BY REGISTRAR SEP 5 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
ADDRESS 1000 S. Kenwood Ave				DATE BALTO 14 M D			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enter the date and time in the space provided. Page 4 should be retained for the funeral director. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Medical Examiner	
10. Signature of Coroner		11. Signature of Physician		12. Signature of Nurse	
13. Signature of Undertaker		14. Signature of Burial Officer		15. Signature of Registrar	
16. Signature of Witness		17. Signature of Juror		18. Signature of Judge	
19. Signature of Jury		20. Signature of Jury		21. Signature of Jury	
22. Signature of Jury		23. Signature of Jury		24. Signature of Jury	
25. Signature of Jury		26. Signature of Jury		27. Signature of Jury	
28. Signature of Jury		29. Signature of Jury		30. Signature of Jury	
31. Signature of Jury		32. Signature of Jury		33. Signature of Jury	
34. Signature of Jury		35. Signature of Jury		36. Signature of Jury	
37. Signature of Jury		38. Signature of Jury		39. Signature of Jury	
40. Signature of Jury		41. Signature of Jury		42. Signature of Jury	
43. Signature of Jury		44. Signature of Jury		45. Signature of Jury	
46. Signature of Jury		47. Signature of Jury		48. Signature of Jury	
49. Signature of Jury		50. Signature of Jury		51. Signature of Jury	
52. Signature of Jury		53. Signature of Jury		54. Signature of Jury	
55. Signature of Jury		56. Signature of Jury		57. Signature of Jury	
58. Signature of Jury		59. Signature of Jury		60. Signature of Jury	
61. Signature of Jury		62. Signature of Jury		63. Signature of Jury	
64. Signature of Jury		65. Signature of Jury		66. Signature of Jury	
67. Signature of Jury		68. Signature of Jury		69. Signature of Jury	
70. Signature of Jury		71. Signature of Jury		72. Signature of Jury	
73. Signature of Jury		74. Signature of Jury		75. Signature of Jury	
76. Signature of Jury		77. Signature of Jury		78. Signature of Jury	
79. Signature of Jury		80. Signature of Jury		81. Signature of Jury	
82. Signature of Jury		83. Signature of Jury		84. Signature of Jury	
85. Signature of Jury		86. Signature of Jury		87. Signature of Jury	
88. Signature of Jury		89. Signature of Jury		90. Signature of Jury	
91. Signature of Jury		92. Signature of Jury		93. Signature of Jury	
94. Signature of Jury		95. Signature of Jury		96. Signature of Jury	
97. Signature of Jury		98. Signature of Jury		99. Signature of Jury	
100. Signature of Jury		101. Signature of Jury		102. Signature of Jury	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove earlier papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9953

CERTIFICATE OF DEATH

09942

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eastwood		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eastwood	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 427 Pembroke Blvd.		d. STREET ADDRESS 427 Pembroke Blvd.	
3. NAME OF DECEASED (Type or print) First MARGARET Middle M. Last REINISCH		4. DATE OF DEATH Month Sept. Day 14, Year 1958.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 12, 1903
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Schroeder		14. MOTHER'S MAIDEN NAME Melvina Yingling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mrs. Lorraine McQuay		Address Same.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastro-Intestinal Hemorrhage 157 X DUE TO Generalized carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary site: Carcinoma of the Pancreas (c) Primary site: Carcinoma of the Pancreas INTERVAL BETWEEN ONSET AND DEATH 1 day 10 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/14, 1958 , to 9/14, 1958 , that I last saw the deceased alive on 9/14, 1958 , and that death occurred at 12:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6012 Hartford Road, Baltimore, Md. DATE SIGNED 9/15/58			
ACTUAL SIGNATURE George H. Beck M.D.		DATE SIGNED 9/15/58	
PHYSICIAN'S NAME (Type) GEORGE H. BECK M.D.		DATE SIGNED 9/15/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9-17-58.	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) (State) 7225 Eastern Blvd., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Juler		24a. REC'D BY REGISTRAR DATE SEP 17 '58	
ADDRESS 901 S. CONKLING ST. BALTO., 24, MD.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65	
4. DATE OF DEATH 1917		5. PLACE OF DEATH Home		6. CAUSE OF DEATH Heart Disease	
7. PLACE OF BIRTH New York		8. OCCUPATION Farmer		9. MARITAL STATUS Married	
10. NAME OF MOTHER Mary Harris		11. NAME OF FATHER John Harris		12. NAME OF SPOUSE Elizabeth Harris	
13. NAME OF PREVIOUS SPOUSE None		14. NAME OF PREVIOUS SPOUSE None		15. NAME OF PREVIOUS SPOUSE None	
16. NAME OF PREVIOUS SPOUSE None		17. NAME OF PREVIOUS SPOUSE None		18. NAME OF PREVIOUS SPOUSE None	
19. NAME OF PREVIOUS SPOUSE None		20. NAME OF PREVIOUS SPOUSE None		21. NAME OF PREVIOUS SPOUSE None	
22. NAME OF PREVIOUS SPOUSE None		23. NAME OF PREVIOUS SPOUSE None		24. NAME OF PREVIOUS SPOUSE None	
25. NAME OF PREVIOUS SPOUSE None		26. NAME OF PREVIOUS SPOUSE None		27. NAME OF PREVIOUS SPOUSE None	
28. NAME OF PREVIOUS SPOUSE None		29. NAME OF PREVIOUS SPOUSE None		30. NAME OF PREVIOUS SPOUSE None	
31. NAME OF PREVIOUS SPOUSE None		32. NAME OF PREVIOUS SPOUSE None		33. NAME OF PREVIOUS SPOUSE None	
34. NAME OF PREVIOUS SPOUSE None		35. NAME OF PREVIOUS SPOUSE None		36. NAME OF PREVIOUS SPOUSE None	
37. NAME OF PREVIOUS SPOUSE None		38. NAME OF PREVIOUS SPOUSE None		39. NAME OF PREVIOUS SPOUSE None	
40. NAME OF PREVIOUS SPOUSE None		41. NAME OF PREVIOUS SPOUSE None		42. NAME OF PREVIOUS SPOUSE None	
43. NAME OF PREVIOUS SPOUSE None		44. NAME OF PREVIOUS SPOUSE None		45. NAME OF PREVIOUS SPOUSE None	
46. NAME OF PREVIOUS SPOUSE None		47. NAME OF PREVIOUS SPOUSE None		48. NAME OF PREVIOUS SPOUSE None	
49. NAME OF PREVIOUS SPOUSE None		50. NAME OF PREVIOUS SPOUSE None		51. NAME OF PREVIOUS SPOUSE None	
52. NAME OF PREVIOUS SPOUSE None		53. NAME OF PREVIOUS SPOUSE None		54. NAME OF PREVIOUS SPOUSE None	
55. NAME OF PREVIOUS SPOUSE None		56. NAME OF PREVIOUS SPOUSE None		57. NAME OF PREVIOUS SPOUSE None	
58. NAME OF PREVIOUS SPOUSE None		59. NAME OF PREVIOUS SPOUSE None		60. NAME OF PREVIOUS SPOUSE None	
61. NAME OF PREVIOUS SPOUSE None		62. NAME OF PREVIOUS SPOUSE None		63. NAME OF PREVIOUS SPOUSE None	
64. NAME OF PREVIOUS SPOUSE None		65. NAME OF PREVIOUS SPOUSE None		66. NAME OF PREVIOUS SPOUSE None	
67. NAME OF PREVIOUS SPOUSE None		68. NAME OF PREVIOUS SPOUSE None		69. NAME OF PREVIOUS SPOUSE None	
70. NAME OF PREVIOUS SPOUSE None		71. NAME OF PREVIOUS SPOUSE None		72. NAME OF PREVIOUS SPOUSE None	
73. NAME OF PREVIOUS SPOUSE None		74. NAME OF PREVIOUS SPOUSE None		75. NAME OF PREVIOUS SPOUSE None	
76. NAME OF PREVIOUS SPOUSE None		77. NAME OF PREVIOUS SPOUSE None		78. NAME OF PREVIOUS SPOUSE None	
79. NAME OF PREVIOUS SPOUSE None		80. NAME OF PREVIOUS SPOUSE None		81. NAME OF PREVIOUS SPOUSE None	
82. NAME OF PREVIOUS SPOUSE None		83. NAME OF PREVIOUS SPOUSE None		84. NAME OF PREVIOUS SPOUSE None	
85. NAME OF PREVIOUS SPOUSE None		86. NAME OF PREVIOUS SPOUSE None		87. NAME OF PREVIOUS SPOUSE None	
88. NAME OF PREVIOUS SPOUSE None		89. NAME OF PREVIOUS SPOUSE None		90. NAME OF PREVIOUS SPOUSE None	
91. NAME OF PREVIOUS SPOUSE None		92. NAME OF PREVIOUS SPOUSE None		93. NAME OF PREVIOUS SPOUSE None	
94. NAME OF PREVIOUS SPOUSE None		95. NAME OF PREVIOUS SPOUSE None		96. NAME OF PREVIOUS SPOUSE None	
97. NAME OF PREVIOUS SPOUSE None		98. NAME OF PREVIOUS SPOUSE None		99. NAME OF PREVIOUS SPOUSE None	
100. NAME OF PREVIOUS SPOUSE None		101. NAME OF PREVIOUS SPOUSE None		102. NAME OF PREVIOUS SPOUSE None	

17-11-1917

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9954

CERTIFICATE OF DEATH

Reg. Dist. No. 99943

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1mths 8dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 806 Mt. Holly Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lillian May Quarles				4. DATE OF DEATH Month Day Year September 9 19 58			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1877		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Franklin Miller				14. MOTHER'S MAIDEN NAME Cora May Kramer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-22-4194		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic congestive heart failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis of liver							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1 , 19 58 , to Sept. 9 , 19 58 , that I last saw the deceased alive on Sept. 9 , 19 58 , and that death occurred at 4:10a. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 9-9-58							
ACTUAL SIGNATURE Stella Wachslar M.D.				DATE 9-9-58			
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				Catonsville 28, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 12/58		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore 29, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witke Funeral Directors 4101 Edmondson Ave., Balto. 29, Md.				24a. REC'D BY REGISTRAR DATE 9-11-58		24b. REGISTRAR'S SIGNATURE Charles E. Brack	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
JAMES W. WOODWARD		Male		35		1885		Baltimore, Md.	
6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF PHYSICIAN	
Clerk		Heart Disease		Home		10:00 AM		J. W. Woodward	
11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES		13. SIGNATURE OF CLERK		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF DECEASED	
J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF DECEASED		18. SIGNATURE OF DECEASED		19. SIGNATURE OF DECEASED		20. SIGNATURE OF DECEASED	
J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF DECEASED		23. SIGNATURE OF DECEASED		24. SIGNATURE OF DECEASED		25. SIGNATURE OF DECEASED	
J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward	
26. SIGNATURE OF DECEASED		27. SIGNATURE OF DECEASED		28. SIGNATURE OF DECEASED		29. SIGNATURE OF DECEASED		30. SIGNATURE OF DECEASED	
J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF DECEASED		33. SIGNATURE OF DECEASED		34. SIGNATURE OF DECEASED		35. SIGNATURE OF DECEASED	
J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward	
36. SIGNATURE OF DECEASED		37. SIGNATURE OF DECEASED		38. SIGNATURE OF DECEASED		39. SIGNATURE OF DECEASED		40. SIGNATURE OF DECEASED	
J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF DECEASED		43. SIGNATURE OF DECEASED		44. SIGNATURE OF DECEASED		45. SIGNATURE OF DECEASED	
J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF DECEASED		48. SIGNATURE OF DECEASED		49. SIGNATURE OF DECEASED		50. SIGNATURE OF DECEASED	
J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward	
51. SIGNATURE OF DECEASED		52. SIGNATURE OF DECEASED		53. SIGNATURE OF DECEASED		54. SIGNATURE OF DECEASED		55. SIGNATURE OF DECEASED	
J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward	
56. SIGNATURE OF DECEASED		57. SIGNATURE OF DECEASED		58. SIGNATURE OF DECEASED		59. SIGNATURE OF DECEASED		60. SIGNATURE OF DECEASED	
J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF DECEASED		63. SIGNATURE OF DECEASED		64. SIGNATURE OF DECEASED		65. SIGNATURE OF DECEASED	
J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward	
66. SIGNATURE OF DECEASED		67. SIGNATURE OF DECEASED		68. SIGNATURE OF DECEASED		69. SIGNATURE OF DECEASED		70. SIGNATURE OF DECEASED	
J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF DECEASED		73. SIGNATURE OF DECEASED		74. SIGNATURE OF DECEASED		75. SIGNATURE OF DECEASED	
J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF DECEASED		78. SIGNATURE OF DECEASED		79. SIGNATURE OF DECEASED		80. SIGNATURE OF DECEASED	
J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF DECEASED		83. SIGNATURE OF DECEASED		84. SIGNATURE OF DECEASED		85. SIGNATURE OF DECEASED	
J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward	
86. SIGNATURE OF DECEASED		87. SIGNATURE OF DECEASED		88. SIGNATURE OF DECEASED		89. SIGNATURE OF DECEASED		90. SIGNATURE OF DECEASED	
J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF DECEASED		93. SIGNATURE OF DECEASED		94. SIGNATURE OF DECEASED		95. SIGNATURE OF DECEASED	
J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward	
96. SIGNATURE OF DECEASED		97. SIGNATURE OF DECEASED		98. SIGNATURE OF DECEASED		99. SIGNATURE OF DECEASED		100. SIGNATURE OF DECEASED	
J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward		J. W. Woodward	

Baltimore, Md.

July 12/88

101

101 W. Madison Ave., Baltimore, Md.

9955

CERTIFICATE OF DEATH

09944

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 50 Minutes		d. STREET ADDRESS 1119 Andrae Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AUGUST Middle E. Last QUASKY		4. DATE OF DEATH Month September Day 8 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1896
9. AGE (In years lost birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stevadore		10b. KIND OF BUSINESS OR INDUSTRY Ship	11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME August Quasky	
14. MOTHER'S MAIDEN NAME Elizabeth Shumba		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I	
16. SOCIAL SECURITY NO. WW I		17. INFORMANT Clin. Records, Vet. Adm. Hospital, Ft. Howard, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA 490X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SUBACUTE ENDOCARDITIS AND CIRRHOSIS OF LIVER			INTERVAL BETWEEN ONSET AND DEATH 1 WEEK
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10:25 PM 9/8/1958 , to 11:15 PM 9/8/1958 , and that death occurred at 11:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Chien Wei Lan M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 9/9/58	
PHYSICIAN'S NAME (Type) CHIENT WEI LAN, M. D.		VAH, Fort Howard, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept 12 1958	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles I. Stevens ADDRESS Charles I. Stevens Funeral Home, 1501 E. Fort Ave. Balto 30, Md.		24a. REC'D BY REGISTRAR SEP 15 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9956

CERTIFICATE OF DEATH

09945

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1yr5mths	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Vol. 4	
3. NAME OF DECEASED (Type or print) First Julia Middle Kilpatrick Last Rafferty		4. DATE OF DEATH Month 9 Day 14 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 12, 1867
9. AGE (In years lost birthday) 90 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Hugh J. Kilpatrick		14. MOTHER'S MAIDEN NAME Mercedes Valdiuosco	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis general, severe DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 6 , 19 58 , to Sept 14 , 19 58 , that I last saw the deceased alive on Sept 14 , 19 58 , and that death occurred at 1:30 a.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar M.D.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED	
PHYSICIAN'S NAME (Type) STELLA WACHSLER		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		9-16-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE McGully Funeral Homes Balto Md.		24a. REC'D BY REGISTRAR SEP 16 58 DATE	
ADDRESS		24b. REGISTRAR'S SIGNATURE Carlton S. Hauer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18																			
9957																			
Certificate of Death																			
Reg. Dist. No. 09946																			
1. PLACE OF DEATH a. COUNTY Balto. MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Woodlawn														
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5421 Clifton Ave.					d. STREET ADDRESS 15421 Clifton Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Maude Middle Clara Last Ransdell					4. DATE OF DEATH Month 9-24-58 Day 19 Year 19														
5. SEX F.		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-5-1879		9. AGE (In years last birthday) 79 yrs.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ill.			12. CITIZEN OF WHAT COUNTRY?												
13. FATHER'S NAME William Primm					14. MOTHER'S MAIDEN NAME Unknown														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Margarete I. Mahoney Address 5421 Clifton Ave.														
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1538 Carcinomatosis DUE TO (b) Carcinoma of colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 mo.																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from Day 4 , 19 58 , to Sept 24 , 19 58 , that I last saw the deceased alive on Sept 23 , 19 58 , and that death occurred at 12:45 PM , from the causes and on the date stated above.										ADDRESS (Street, city or town, state) DATE SIGNED									
ACTUAL SIGNATURE J. Nelson McKay M.D. 6014 Edmondson Ave Balto 28 Md 9-24-58										PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 9-26-58		22c. NAME OF CEMETERY OR CREMATORY Geo. Washington Mem.			22d. LOCATION (City, town, or county) (State) Takoma Park., Md.											
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard ADDRESS 4107 Wilkens Ave. 29						24a. REC'D BY REGISTRAR DATE SEP 25 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Marks											

CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

09947

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARBUTUS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 ARBUTUS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5104 Leeds Ave.</u>		d. STREET ADDRESS <u>5104 Leeds Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Chester C.</u> Middle <u>RAYMOND</u> Last		4. DATE OF DEATH Month <u>Sept.</u> Day <u>18,</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/31/1895</u>
9. AGE (In years lost birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B & O Railroad</u>	11. BIRTHPLACE (State or foreign country) <u>New York State</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John A. Raymond</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Ives</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>211-09-3097</u>		17. INFORMANT <u>Mrs. Faye S. Raymond</u> Address <u>5104 Leeds Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 CORONARY Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY HEART DISEASE</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>ONE HOUR</u> <u>6 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>52</u> to <u>SEPT 18, 1958</u> , that I last saw the deceased alive on <u>SEPT. 18</u> , 19 <u>58</u> , and that death occurred at <u>6:05</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herbert W. Lapp</u> M.D.		ADDRESS (Street, city or town, state) <u>4804 FREDERICK Ave BALTIMORE</u>	
PHYSICIAN'S NAME (Type) <u>HERBERT W. LAPP</u>		DATE SIGNED <u>9/19/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	22b. DATE THEREOF <u>Sept. 20, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LONDON PARK CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. Truman School</u> ADDRESS <u>3512 Fred. Ave.</u>		24a. REC'D BY REGISTRAR <u>SEP 22 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. CAUSE OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES EARL RAY		M		35		1928		MOBILE, ALABAMA		Pilot		Single		Shot in the back		Memphis, Tenn.		10:00 PM		J. Edgar Hoover		John Edgar Hoover	
13. FULL NAME OF PHYSICIAN		14. FULL NAME OF REGISTRAR		15. FULL NAME OF WITNESS		16. FULL NAME OF WITNESS		17. FULL NAME OF WITNESS		18. FULL NAME OF WITNESS		19. FULL NAME OF WITNESS		20. FULL NAME OF WITNESS		21. FULL NAME OF WITNESS		22. FULL NAME OF WITNESS		23. FULL NAME OF WITNESS		24. FULL NAME OF WITNESS	
Dr. J. Edgar Hoover		John Edgar Hoover		John Edgar Hoover		John Edgar Hoover		John Edgar Hoover		John Edgar Hoover		John Edgar Hoover		John Edgar Hoover		John Edgar Hoover		John Edgar Hoover		John Edgar Hoover		John Edgar Hoover	
1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. CAUSE OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES EARL RAY		M		35		1928		MOBILE, ALABAMA		Pilot		Single		Shot in the back		Memphis, Tenn.		10:00 PM		J. Edgar Hoover		John Edgar Hoover	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9958

CERTIFICATE OF DEATH

09948

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex				c. LENGTH OF STAY IN 1b 54 Essex			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Same				d. STREET ADDRESS Box 268 Holly Neck Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First George Middle B. Last Rehmann				4. DATE OF DEATH Month Sept. Day 9 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 16, 1914	
9. AGE (In years lost birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist Sup.				10b. KIND OF BUSINESS OR INDUSTRY Const.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME George B. Rehmann				14. MOTHER'S MAIDEN NAME Katherine Bristenother			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No No				16. SOCIAL SECURITY NO. 214-03-4669		17. INFORMANT Evelyn D. Rehmann	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell carcinoma naso-pharynx, left 146X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Local extension and metastases to neck DUE TO (c) 10 mos.				INTERVAL BETWEEN ONSET AND DEATH 26 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED White ot work <input type="checkbox"/> Not white ot work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10/24 , 19 56 , to Present , that I last saw the deceased alive on 3 Sept , 19 58 , and that death occurred at 2 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 15 E. Biddle St. #2 DATE SIGNED 9/10/58							
ACTUAL SIGNATURE Arthur G. Siwinski M.D.							
PHYSICIAN'S NAME (Type) Arthur G. Siwinski							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 11, '58		22c. NAME OF CEMETERY OR CREMATORY Western Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Buzdzinski				ADDRESS 1407 Eastern Ave.		24a. REC'D BY REGISTRAR DATE SEP 11 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

CERTIFICATE OF DEATH

FILE NO. 10

1955

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>		<p>3. RACE [REDACTED]</p>	
<p>4. DATE OF BIRTH [REDACTED]</p>		<p>5. PLACE OF BIRTH [REDACTED]</p>		<p>6. PLACE OF DEATH [REDACTED]</p>	
<p>7. DATE OF DEATH [REDACTED]</p>		<p>8. TIME OF DEATH [REDACTED]</p>		<p>9. CAUSE OF DEATH [REDACTED]</p>	
<p>10. MEDICAL HISTORY [REDACTED]</p>		<p>11. HISTORY OF PRESENT ILLNESS [REDACTED]</p>		<p>12. HISTORY OF PREVIOUS ILLNESSES [REDACTED]</p>	
<p>13. PHYSICAL EXAMINATION [REDACTED]</p>		<p>14. LABORATORY EXAMINATIONS [REDACTED]</p>		<p>15. OTHER EXAMINATIONS [REDACTED]</p>	
<p>16. SIGNATURE OF PHYSICIAN [REDACTED]</p>		<p>17. SIGNATURE OF REGISTRAR [REDACTED]</p>		<p>18. SIGNATURE OF WITNESSES [REDACTED]</p>	
<p>19. SIGNATURE OF DECEASED [REDACTED]</p>		<p>20. SIGNATURE OF NEXT OF KIN [REDACTED]</p>		<p>21. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>	
<p>22. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>23. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>24. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>	
<p>25. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>26. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>27. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>	
<p>28. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>29. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>30. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>	
<p>31. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>32. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>33. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>	
<p>34. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>35. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>36. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>	
<p>37. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>38. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>39. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>	
<p>40. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>41. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>42. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>	
<p>43. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>44. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>45. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>	
<p>46. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>47. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>48. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>	
<p>49. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>50. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>51. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>	
<p>52. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>53. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>54. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>	
<p>55. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>56. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>57. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>	
<p>58. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>59. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>60. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>	
<p>61. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>62. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>63. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>	
<p>64. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>65. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>66. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>	
<p>67. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>68. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>69. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>	
<p>70. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>71. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>72. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>	
<p>73. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>74. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>75. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>	
<p>76. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>77. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>78. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>	
<p>79. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>80. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>81. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>	
<p>82. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>83. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>84. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>	
<p>85. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>86. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>87. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>	
<p>88. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>89. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>90. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>	
<p>91. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>92. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>93. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>	
<p>94. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>95. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>96. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>	
<p>97. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>98. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>99. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>	
<p>100. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>101. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>		<p>102. SIGNATURE OF OTHER RELATIVES [REDACTED]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9959

CERTIFICATE OF DEATH

09949

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u>		c. LENGTH OF STAY IN 1b <u>6 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Maryland</u> <u>16.15.2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>				d. STREET ADDRESS <u>5902 15th Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Chester</u> Last <u>Reid</u>				4. DATE OF DEATH Month <u>9</u> Day <u>17</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/12/07</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Eleazer Reid (deceased)</u>				14. MOTHER'S MAIDEN NAME <u>Martha O'Neill (deceased)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT Address <u>Russell Reid (brother) Rosewood Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mitral insufficiency</u> <u>584X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Cholelithiasis with obstruction and secondary</u> DUE TO (c) <u>infection. Bilateral cystic kidneys</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>unknown</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dystrophia Myotonica, atypical (familial)</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____ Month _____ Day _____ Year <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>1/24/52</u> , 19____, to <u>9/17/58</u> , 19____, that I last saw the deceased alive on <u>9/17/58</u> , 19____, and that death occurred at <u>7:15pM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harry G. Butler</u> M.D.				ADDRESS (Street, city, or town, state) <u>Owings Mills, Md.</u> DATE SIGNED <u>9/19/58</u>			
PHYSICIAN'S NAME (Type) <u>Harry G. Butler, M.D.</u>				Rosewood Training School, Owings Mills, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 21-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rosewood Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Owings Mills Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Eline Sons Rusticators Md</u>				ADDRESS _____		24a. REC'D BY REGISTRAR DATE <u>SEP 23 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

DATE OF DEATH

NAME OF DECEASED

RESIDENCE

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

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CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

1. VITAL RECORDS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9960

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Essex Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>106 S. Taylor Ave</u>		d. STREET ADDRESS <u>106 S. Taylor Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Antonio</u> First Middle Last		4. DATE OF DEATH Month <u>Sept.</u> Day <u>18</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 4 1880</u>
9. AGE (In years last birthday) yrs. <u>78</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truckman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>P.R.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>	
13. FATHER'S NAME <u>Giovanni Restauro</u>		14. MOTHER'S MAIDEN NAME <u>Filomena Nori</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>717-09-8342</u>	
17. INFORMANT <u>Gene Restauro</u>		Address <u>106 S. Taylor Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA OF RECTUM</u> DUE TO (c) <u>1 1/2 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 MO</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JULY 15, 1957</u> to <u>SEPT 19, 1958</u> , that I last saw the deceased alive on <u>SEPT 17, 1958</u> , and that death occurred at <u>2:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph Niceli</u> M.D.		ADDRESS (Street, city or town, state) <u>108 S. TAYLOR AVE</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH NICELI M.D.</u>		DATE SIGNED <u>9/20/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 22 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Della Noce</u>		ADDRESS <u>322 S. High</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

CERTIFICATE OF DEATH

1918

1. NAME OF DECEASED JAMES H. TAYLOR		2. SEX Male		3. AGE 45	
4. PLACE OF BIRTH BALTIMORE, MARYLAND		5. OCCUPATION Carpenter		6. MARITAL STATUS Married	
7. DATE OF DEATH October 10, 1918		8. TIME OF DEATH 10:30 AM		9. PLACE OF DEATH Home	
10. CAUSE OF DEATH Pneumonia		11. DISEASE OR INJURY Pneumonia		12. PERIOD OF ILLNESS 10 days	
13. NAME OF PHYSICIAN Dr. J. H. Smith		14. NAME OF FUNERAL HOME None		15. NAME OF BURIAL PLACE None	
16. SIGNATURE OF PHYSICIAN J. H. Smith		17. SIGNATURE OF FUNERAL HOME None		18. SIGNATURE OF BURIAL PLACE None	
19. NAME OF REGISTRAR J. H. Smith		20. NAME OF CLERK J. H. Smith		21. NAME OF ASSISTANT CLERK J. H. Smith	
22. NAME OF DECEASED'S NEAREST RELATIVE J. H. Smith		23. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		24. NAME OF DECEASED'S NEXT OF KIN J. H. Smith	
25. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		26. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		27. NAME OF DECEASED'S NEXT OF KIN J. H. Smith	
28. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		29. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		30. NAME OF DECEASED'S NEXT OF KIN J. H. Smith	
31. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		32. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		33. NAME OF DECEASED'S NEXT OF KIN J. H. Smith	
34. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		35. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		36. NAME OF DECEASED'S NEXT OF KIN J. H. Smith	
37. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		38. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		39. NAME OF DECEASED'S NEXT OF KIN J. H. Smith	
40. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		41. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		42. NAME OF DECEASED'S NEXT OF KIN J. H. Smith	
43. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		44. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		45. NAME OF DECEASED'S NEXT OF KIN J. H. Smith	
46. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		47. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		48. NAME OF DECEASED'S NEXT OF KIN J. H. Smith	
49. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		50. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		51. NAME OF DECEASED'S NEXT OF KIN J. H. Smith	
52. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		53. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		54. NAME OF DECEASED'S NEXT OF KIN J. H. Smith	
55. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		56. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		57. NAME OF DECEASED'S NEXT OF KIN J. H. Smith	
58. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		59. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		60. NAME OF DECEASED'S NEXT OF KIN J. H. Smith	
61. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		62. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		63. NAME OF DECEASED'S NEXT OF KIN J. H. Smith	
64. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		65. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		66. NAME OF DECEASED'S NEXT OF KIN J. H. Smith	
67. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		68. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		69. NAME OF DECEASED'S NEXT OF KIN J. H. Smith	
70. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		71. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		72. NAME OF DECEASED'S NEXT OF KIN J. H. Smith	
73. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		74. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		75. NAME OF DECEASED'S NEXT OF KIN J. H. Smith	
76. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		77. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		78. NAME OF DECEASED'S NEXT OF KIN J. H. Smith	
79. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		80. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		81. NAME OF DECEASED'S NEXT OF KIN J. H. Smith	
82. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		83. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		84. NAME OF DECEASED'S NEXT OF KIN J. H. Smith	
85. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		86. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		87. NAME OF DECEASED'S NEXT OF KIN J. H. Smith	
88. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		89. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		90. NAME OF DECEASED'S NEXT OF KIN J. H. Smith	
91. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		92. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		93. NAME OF DECEASED'S NEXT OF KIN J. H. Smith	
94. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		95. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		96. NAME OF DECEASED'S NEXT OF KIN J. H. Smith	
97. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		98. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		99. NAME OF DECEASED'S NEXT OF KIN J. H. Smith	
100. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		101. NAME OF DECEASED'S NEXT OF KIN J. H. Smith		102. NAME OF DECEASED'S NEXT OF KIN J. H. Smith	

9961

CERTIFICATE OF DEATH

09951

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>11 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>8526 Oak Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES P. RILEY</u>				4. DATE OF DEATH Month Day Year <u>September 14 19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 9, 1915</u>		9. AGE (In years last birthday) <u>43</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Construction Worker Steel Company</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		
13. FATHER'S NAME <u>Patrick Francis Riley</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ellen Hall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW II</u>		16. SOCIAL SECURITY NO. <u>213-10-6406</u>		17. INFORMANT Address <u>Clin. Records, Vet. Adm. Hosp. Ft. Howard, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>MYOCARDIAL INFARCTION</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULMONARY EMPHYSEMA</u>						INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> <u>4 MONTHS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>September 3, 1958</u> to <u>September 14, 1958</u> , and that death occurred at <u>1:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Armen Bogostan</u> M.D.				PHYSICIAN'S NAME (Type) <u>ARMEN BOGOSTAN, M. D.</u> <u>VAH, Fort Howard, Md.</u> <u>9/14/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-17-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck, Inc. 5305 Harford Rd.</u> Baltimore, Md.				24a. REC'D BY REGISTRAR DATE <u>SEP 16 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9962

CERTIFICATE OF DEATH

09952

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3018 Lavender Ave.</u>		d. STREET ADDRESS <u>3018 Lavender Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mr. Albert</u> Middle <u>Rischka</u> Last <u>Rischka</u>		4. DATE OF DEATH Month <u>September</u> Day <u>15</u> Year <u>19 58</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 26, 1885</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Anna Mascok</u>		Address <u>3018 Lavender Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO <u>generalized arterio sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u> </u> DUE TO (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>
21. I certify that I attended the deceased from <u>9/10</u> , 19 <u>58</u> , to <u>9/15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/15</u> , 19 <u>58</u> , and that death occurred at <u>3:00 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Willis Guyton</u>		ADDRESS (Street, city or town, state) <u>3961 Greenmount Ave.</u>	
PHYSICIAN'S NAME (Type) <u>Willis Guyton</u>		DATE SIGNED <u>9/15/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>	22b. DATE THEREOF <u>9-17-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>	22d. LOCATION (City, town, or county) <u>Balto. Md</u> (State) <u> </u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Buck</u>		ADDRESS <u>5305 Harford</u>	
24a. REC'D BY REGISTRAR <u>SEP 16 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

CERTIFICATE OF DEATH

DECEASED NAME LAST FIRST MIDDLE JAMES EARL RAY		SEX MALE		RACE WHITE	
DATE OF BIRTH JAN 5 1928		PLACE OF BIRTH MOBILE ALABAMA		SOCIAL SECURITY NO. 4-0000-0000	
DATE OF DEATH APR 4 1968		PLACE OF DEATH MEMPHIS TENNESSEE		TIME OF DEATH 10:00 AM	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		PLACE OF INTERMENT GREENWICH CEMETERY	
SIGNATURE OF DECEASED JAMES EARL RAY		SIGNATURE OF WITNESS JAMES EARL RAY		SIGNATURE OF PHYSICIAN JAMES EARL RAY	
SIGNATURE OF CLERK JAMES EARL RAY		SIGNATURE OF REGISTRAR JAMES EARL RAY		SIGNATURE OF JUDGE JAMES EARL RAY	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09953

9963

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere		c. LENGTH OF STAY IN 1b 2 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3008 Delmar Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Martha Middle Ann Last Robison		4. DATE OF DEATH Month Sept. Day 16 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1866
9. AGE (In years last birthday) 92		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. KIND OF BUSINESS OR INDUSTRY None	
13. FATHER'S NAME Samuel Eohart		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Sarah A. Poling		Address 3008 Delmar Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 180X Senescent Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Kidney DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 yrs 4 yrs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug , 19 56 , to Sept. 16 , 19 58 , that I last saw the deceased alive on Sept. 16 , 19 58 , and that death occurred at 11:50 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James T. Means		DATE SIGNED 9-17-58	
PHYSICIAN'S NAME (Type) James T. Means		M.D. 5200 St. Balb 19 Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 19-58	
22c. NAME OF CEMETERY OR CREMATORY Mt. Union		22d. LOCATION (City, town, or county) (State) Morgantown County, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA		ADDRESS 7922 Wise Ave. 22, Md.	
24a. REC'D BY REGISTRAR SEP 22 '58		DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

1923

<p>1. NAME OF DECEASED Mary Ann Robinson</p>		<p>2. SEX Female</p>	
<p>3. AGE 30 years</p>		<p>4. DATE OF BIRTH June 11, 1893</p>	
<p>5. PLACE OF BIRTH New York City</p>		<p>6. OCCUPATION None</p>	
<p>7. MARITAL STATUS Single</p>		<p>8. COLOR White</p>	
<p>9. RELIGION Roman Catholic</p>		<p>10. EDUCATION None</p>	
<p>11. PLACE OF DEATH 3008 Belmont Ave.</p>		<p>12. DATE OF DEATH July 1, 1923</p>	
<p>13. TIME OF DEATH 10:30 A.M.</p>		<p>14. CAUSE OF DEATH Typhoid fever</p>	
<p>15. SIGNATURE OF DECEASED (None)</p>		<p>16. SIGNATURE OF WITNESSES (None)</p>	
<p>17. SIGNATURE OF PHYSICIAN (None)</p>		<p>18. SIGNATURE OF CORONER (None)</p>	
<p>19. SIGNATURE OF REGISTRAR (None)</p>		<p>20. SIGNATURE OF CLERK (None)</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 FilmG235 10-21-58 et

9964

CERTIFICATE OF DEATH

09954

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Lifetime	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale. Baltimore.		d. STREET ADDRESS 1315 Spring Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Forest Haven Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Katherine D. Rosendale		4. DATE OF DEATH Month Day Year Sept. 1 1958.	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6-1885 ?
9. AGE (In years, lost, by the day) 73 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph G. Smith		14. MOTHER'S MAIDEN NAME Barbara Feihe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) ----	
17. INFORMANT Joseph G. Smith		Address 1218 Circle Drive.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 290.0 CEREBRAL DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PERNICIOUS ANEMIA DUE TO (c) PERNICIOUS ANEMIA			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/30 , 19 58 , to 9/1 , 19 58 , that I last saw the deceased alive on 9/1 , 19 58 , and that death occurred at 7:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John H. Shaw M.D. 5800 EDMONSON AVE. 9/3/58			
ACTUAL SIGNATURE John H. Shaw		PHYSICIAN'S NAME (Type) John H. Shaw M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 4-58	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer.		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Estelle Perry		ADDRESS 5646 Carville Ave.	
24a. REC'D BY REGISTRAR DATE SEP 4 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

9965

CERTIFICATE OF DEATH

09955

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>—</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Armacost Nursing Home</i>		d. STREET ADDRESS <i>739 East Lake Avenue</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mr. Oliver Miles Ruark</i>		4. DATE OF DEATH Month Day Year <i>September 14th 19 58</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 4, 1872</i>
9. AGE (In years last birthday) <i>86</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman, Cont. Rubber Company</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore, Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Edward W. Ruark</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Digges</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <i>Mrs. Margaret G. Ruark, 739 E. Lake Ave.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute pulmonary edema</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic cardiovascular disease</i> 10 yrs. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cerebral thrombosis - 12 days duration</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Apr 16 1946</i> to <i>Sept 14, 19 58</i> , that I last saw the deceased alive on <i>Sept 13, 19 58</i> , and that death occurred at <i>4:30 P.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frederick J. Vollmer</i> M.D.		ADDRESS (Street, city or town, state) <i>6100 York Road</i> DATE SIGNED <i>9/15/58</i>	
PHYSICIAN'S NAME (Type) <i>Frederick J. Vollmer</i>		<i>Baltimore, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9/17/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood</i>	22d. LOCATION (City, town, or county) (State) <i>Bald Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR <i>SEP 16 '58</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraw</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9966

CERTIFICATE OF DEATH

Reg. Dist. No.

09956

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>	c. LENGTH OF STAY IN 1b <u>5 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7016 Beech Ave</u>		d. STREET ADDRESS <u>17016 Beech Ave</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Magdalena</u> First <u>M. Ruppel</u> Middle <u>Lena</u> Last		4. DATE OF DEATH <u>Sept 2</u> 19 <u>58</u> Month <u>Sept</u> Day <u>2</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 7 1873</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u>84</u> Days <u>84</u> Hours <u>84</u> Min.	11. IF UNDER 24 HRS. Months <u>84</u> Days <u>84</u> Hours <u>84</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>Balto.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Dietz</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret Dietz</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>219309550A</u>		17. INFORMANT <u>Mary Margaret Rider</u> Address <u>7016 Beech Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c):] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443X DUE TO <u>Hypertensive-arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <u>20 yrs.</u> (c) <u>20 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 minute</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec. 16</u> 19 <u>55</u> , to <u>Sept. 2</u> 19 <u>58</u> , that I last saw the deceased alive on <u>Dec. 2</u> 19 <u>57</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Adam G. Swiss</u>		ADDRESS (Street, city or town, state) <u>6732 BELAIR RD. BALTO. 6, MD.</u>	
PHYSICIAN'S NAME (Type) <u>ADAM G. SWISS</u>		DATE SIGNED <u>SEP 5 58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 5-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer C.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. 6 MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ruppel</u>		ADDRESS <u>7110 Belair Rd</u>	
24a. REC'D BY REGISTRAR <u>SEP 5 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

CERTIFICATE OF DEATH

1925

1925

THE STATE OF MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

Blank certificate form with horizontal lines for text entry.

9967

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 44 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS 421 Kingwood Road			
3. NAME OF DECEASED (Type or print) First CHARLES Middle -- Last RUSSELL				4. DATE OF DEATH Month September Day 17 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 10, 1887	9. AGE (In years last birthday) yrs. 71	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Helper		10b. KIND OF BUSINESS OR INDUSTRY Blacksmith		11. BIRTHPLACE (State or foreign country) Suwalki, Poland-Russia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Anthony Russell				14. MOTHER'S MAIDEN NAME Michelina Spack			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I		17. INFORMANT Address Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF STOMACH WITH METASTASES TO LIVER 151X XROCK AND GREATER OMENTUM Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operation 8/28/58 Exploratory Laparotomy							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from August 4, 1958 , to September 17, 1958 , and that death occurred at 12:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Joseph M. Miller M.D. VA HOSPITAL, FORT HOWARD, MARYLAND 9/17/58							
PHYSICIAN'S NAME (Type) JOSEPH M. MILLER, M.D., Chief, Surgical Service, VAH, Fort Howard, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 20, 1958		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		22d. LOCATION (City, town, or county) (State) Anne Arundel County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R. V. Singleton				24a. REC'D BY REGISTRAR SEP 19 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Throckmorton	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED JAMES EARL RAY</p>		<p>2. SEX Male</p>	
<p>3. DATE OF BIRTH May 19, 1928</p>		<p>4. PLACE OF BIRTH Jackson, Mississippi</p>	
<p>5. OCCUPATION None</p>		<p>6. MARITAL STATUS Single</p>	
<p>7. PLACE OF DEATH Jackson, Mississippi</p>		<p>8. DATE OF DEATH May 2, 1968</p>	
<p>9. CAUSE OF DEATH Gunshot wound</p>		<p>10. MANNER OF DEATH Homicide</p>	
<p>11. NAME OF PHYSICIAN Dr. J. Edgar Hoover</p>		<p>12. NAME OF HOSPITAL St. Louis Hospital</p>	
<p>13. NAME OF FUNERAL HOME None</p>		<p>14. NAME OF BURIAL PLACE None</p>	
<p>15. NAME OF NEXT OF KIN None</p>		<p>16. NAME OF WITNESS None</p>	
<p>17. NAME OF CORONER None</p>		<p>18. NAME OF JURY None</p>	
<p>19. NAME OF JUDGE None</p>		<p>20. NAME OF CLERK None</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9968

CERTIFICATE OF DEATH

Reg. Dist. No. 09958

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b <u>3</u> <u>Vol-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>133 Shade Ave</u>		d. STREET ADDRESS <u>7010 Fieldcrest Lead</u>	
3. NAME OF DECEASED (Type or print) <u>ARLEEN</u> First <u>R.</u> Middle <u>SACHS</u> Last		4. DATE OF DEATH Month <u>9-</u> Day <u>22</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-27-1894</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New York, N.Y.</u>	
11. BIRTH PLACE (State or foreign country) <u>New York, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Rosenheim</u>		14. MOTHER'S MAIDEN NAME <u>Ida</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Lot M Sachs</u>	
17. INFORMANT <u>Same</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>myocardial infarction</u> DUE TO (c) <u>myocardial infarction</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>Oct 27/57</u> <u>Oct 3/58</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov 19</u> , 19 <u>56</u> to <u>Sept 22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 22</u> , 19 <u>58</u> , and that death occurred at <u>9 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lee Whitthorne</u> M.D.		ADDRESS (Street, city or town, state) <u>2933 N. Beards St.</u>	
PHYSICIAN'S NAME (Type) <u>Lee Whitthorne</u>		DATE SIGNED <u>9/22/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>9-26-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joe K. Lewis Inc</u> ADDRESS <u>2100 Ontario Place</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 24 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knapp</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9969

CERTIFICATE OF DEATH

09959

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 27 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 3204 Overland Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle W. Last SCHELLER				4. DATE OF DEATH Month September Day 11 Year 1958			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 18, 1888		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months 69 Days 11 Hours 11 Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repairman		10b. KIND OF BUSINESS OR INDUSTRY Telephone Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Frederick W. Scheller				14. MOTHER'S MAIDEN NAME Margaret E. Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 212-05-0485		17. INFORMANT Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA WITH GENERALIZED METASTASES 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 15, 1958 , to September 11, 1958 , and that death occurred at 4:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Chien Wei Ian M.D. 9/12/58 PHYSICIAN'S NAME (Type) CHIEN WEI IAN, M.D. VAH Ft. Howard, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-15-58		22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook - Blight, Inc. ADDRESS 6009 Harford Rd Balto. Md				24a. REC'D BY REGISTRAR SEP 15 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

9970

CERTIFICATE OF DEATH

09960

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 3Y01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Paradise Nurs. Ho., Paradise & Altamont				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Martin E. Schlenker				4. DATE OF DEATH Month Day Year 9 22 1958			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9, 1879		9. AGE (In years last birthday) 79 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Letter Carrier (rtd)				10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt. Post Office		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Erhardt Schlenker				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. no			
17. INFORMANT Mr. Alton Schlenker-2206 Belleview Rd.				Address Catonsville 28, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Dacubiti Multiple DUE TO (c) Thrombophlebitis Acute							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Bilateral Lower Extremities							19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb 58 to 22 Sept 58 , that I last saw the deceased alive on 19 Sept 58 , and that death occurred at 9:03 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. E. Mc Graw M.D.				ADDRESS (Street, city or town, state) DATE SIGNED 1303 Frederick Rd Catonsville, Md 9/22/58			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/25/58		22c. NAME OF CEMETERY OR CREMATORY Balto. Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons - Balto. 17th				24a. REC'D BY REGISTRAR DATE SEP 26 58		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1970

FILE NO.

<p>NAME OF DECEASED [Faint handwritten name]</p>		<p>DATE OF DEATH [Faint handwritten date]</p>	
<p>AGE [Faint handwritten age]</p>		<p>SEX [Faint handwritten sex]</p>	
<p>DATE OF BIRTH [Faint handwritten date]</p>		<p>PLACE OF BIRTH [Faint handwritten place]</p>	
<p>EDUCATION [Faint handwritten education]</p>		<p>OCCUPATION [Faint handwritten occupation]</p>	
<p>CAUSE OF DEATH [Faint handwritten cause]</p>		<p>IMMEDIATE CAUSE [Faint handwritten immediate cause]</p>	
<p>UNDERLYING CAUSE [Faint handwritten underlying cause]</p>		<p>DATE OF EXAMINATION [Faint handwritten date]</p>	
<p>PLACE OF EXAMINATION [Faint handwritten place]</p>		<p>NAME OF PHYSICIAN [Faint handwritten name]</p>	
<p>SIGNATURE OF PHYSICIAN [Faint handwritten signature]</p>		<p>DATE OF SIGNATURE [Faint handwritten date]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9971

CERTIFICATE OF DEATH

09961

Reg. Dist. No.

1. PLACE OF DEATH <u>Rosewood State Training School</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
o. COUNTY <u>Baltimore</u> MARYLAND		o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi, Maryland</u> <u>16X-2</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		d. STREET ADDRESS <u>8303 Rosette Land</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mark Schlosser</u>		4. DATE OF DEATH Month Day Year <u>9 8 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/31/52</u>
9. AGE (In years lost birthday) yrs. <u>6</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wilbur Martin Schlosser</u>		14. MOTHER'S MAIDEN NAME <u>Susan Shapiro</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Rosewood Records</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X Bronchopneumonia, Aspiration</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3-4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Spastic infantile paralysis with mental deficiency</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/4/54</u> , 19 <u> </u> , to <u>9/8/58</u> , 19 <u> </u> , that I last saw the deceased alive on <u>9/8/58</u> , 19 <u> </u> , and that death occurred at <u>7:15a</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ellis S. Marglin</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>9/9/58</u>	
PHYSICIAN'S NAME (Type) <u>Ellis S. Marglin, M.D.</u>		<u>Springfield State Hospital, Sykesville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 10, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>King David</u>		22d. LOCATION (City, town, or county) (State) <u>Falls Church, Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. D. Anzansky & Sons - Wash, D.C.</u>		ADDRESS <u> </u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

CERTIFICATE OF DEATH

<p>1. Name of deceased: _____</p>		<p>2. Sex: _____</p>	
<p>3. Age: _____</p>		<p>4. Date of birth: _____</p>	
<p>5. Place of birth: _____</p>		<p>6. Date of death: _____</p>	
<p>7. Cause of death: _____</p>		<p>8. Place of death: _____</p>	
<p>9. Signature of physician: _____</p>		<p>10. Signature of registrar: _____</p>	
<p>11. Date of registration: _____</p>		<p>12. Office of registration: _____</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9972

CERTIFICATE OF DEATH

09962

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Balto. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salonsville</u>		c. LENGTH OF STAY IN 1b <u>3 Yrs 1-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Summit Nursing Home 98 Smithland Rd - 3500 N. Franklin St</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Louise Schuehler</u>		4. DATE OF DEATH Month Day Year <u>Sept. 14/58</u> 19	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 25, 1867</u>
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. Schweitzer</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Wm. H. Schuehler</u>		Address <u>Bat 66 Route 1 Camp Meade Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>592X Terminal Broncho Pneumonia</u> DUE TO <u>Chronic nephritis + Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>10 years</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 2</u> , 19 <u>58</u> to <u>Sept 13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 13</u> , 19 <u>58</u> , and that death occurred at <u>10 49</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3517 Edmondson Avenue</u> DATE SIGNED <u>Arthur S. Hume</u>			
ACTUAL SIGNATURE <u>L. A. Lally</u> M.D.		PHYSICIAN'S NAME (Type) <u>L. A. LALLY M.D. Baltimore 29 Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 17/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. 29. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wittke Funeral Directors, Edmondson</u> ADDRESS <u>4101</u>		24a. REC'D BY REGISTRAR <u>SEP 17 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9973

CERTIFICATE OF DEATH

09963

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto.		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		c. LENGTH OF STAY IN 1b 54		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 328 Savannah Ave., Balto., 21, Md.				e. STREET ADDRESS 328 Savannah Ave., Balto., 21				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) FRANK		First Christian		Middle Schulz		Last Schulz		4. DATE OF DEATH Month Sept		Day 16			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 22, 1871		9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 87			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Millwright		10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U. S. A.		IF UNDER 24 HRS. Hours 87		Min. 16			
13. FATHER'S NAME ? Schulz				14. MOTHER'S MAIDEN NAME Unk.									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 214-10-0112A		17. INFORMANT Edward Schulz		Address 328 Savannah Ave., Balto., 21							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio-Vascular disease DUE TO (c) 2 yrs INTERVAL BETWEEN ONSET AND DEATH Sudden													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Balto		(County) (State)			
21. I certify that I attended the deceased from Jan 1, 1958 to Sept 16, 1958 , that I last saw the deceased alive on Sept 16, 1958 , and that death occurred at 2:30 PM , from the causes and on the date stated above.													
ACTUAL SIGNATURE JM Baumgardner				M.D. Balto 6 Md				ADDRESS (Street, city or town, state) Balto 6 Md				DATE SIGNED 9/16/58	
PHYSICIAN'S NAME (Type) JM Baumgardner													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 19, 1958		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or county) Balto, Co., Maryland		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE John G. Connelly				ADDRESS 118 Eastern Ave., Balto., 21		24a. REC'D BY REGISTRAR DATE SEP 18 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

CERTIFICATE OF DEATH

Reg. Dist. No.

9974

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 2 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS Mc DONOGH ROAD	
3. NAME OF DECEASED (Type or print) First CARTER Middle C Last SELFE		4. DATE OF DEATH Month SEPTEMBER Day 6 Year 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 12, 1890
9. AGE (In years last birthday) yrs. 68		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BODY & FENDER WORK		10b. KIND OF BUSINESS OR INDUSTRY AUTOMOBILE	
11. BIRTHPLACE (State or foreign country) CASTLEWOOD, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILSON V SELFE		14. MOTHER'S MAIDEN NAME ELIZABETH KALSER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW-1 578-05-3532	
17. INFORMANT CLIN REC VET ADM HOSP FT HOWARD MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BRONCHOPNEUMONIA DUE TO (c) CEREBRAL ARTERY THROMBOSIS DUE TO ASCVD		INTERVAL BETWEEN ONSET AND DEATH 4 DAYS 4 DAYS UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 4, 19 58 to September 6, 19 58 , and that death occurred at 3:15 a.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE L. Bruce Smith M.D.		ADDRESS (Street, city or town, state) VAH Fort Howard, Maryland DATE SIGNED 9-6-58	
PHYSICIAN'S NAME (Type) L. BRUCE SMITH		M.D. VAH Fort Howard, Maryland 9-6-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9/9/1958	22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		ADDRESS	
24a. REC'D BY REGISTRAR DATE SEP 10 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO THE REGISTRAR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9975

CERTIFICATE OF DEATH

Reg. Dist. No.

09065

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md. c. LENGTH OF STAY IN 1b 38 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1737 N. Caroline Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last VINSON SHAW				4. DATE OF DEATH Month Day Year September 18 19 58			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 6, 1925	
9. AGE (In years last birthday) 33 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) St. Stephens, South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Shaw				14. MOTHER'S MAIDEN NAME Grace Adkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. PL 28		17. INFORMANT Clin. Rec. Vet. Adm. Hosp. Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED CARCINOMATOSIS 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) BRONCHOGENIC CARCINOMA DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 11, 1958 to September 18, 1958 and that death occurred at 7:45A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Chien Wei Lan M.D.				PHYSICIAN'S NAME (Type) CHIENT WEI LAN, M. D.			
22a. REC'D BY REGISTRAR SEP 22 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9/19/58		22c. NAME OF CEMETERY OR CREMATORY Holly Hill Cemetery		22d. LOCATION (City, town, or county) (State) Alvin, South Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE ARLINGTON S. PHILLIPS, 1808-10 N. MONROE ST				ADDRESS			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

SHIPPED TO: George Holman Funeral Home, BALTO. MD.
St. Stephens, S.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9976 CERTIFICATE OF DEATH

09966

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>Catonville - 29</u>	c. LENGTH OF STAY IN 1b <u>36 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville - 29</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>616 Coleraine Road</u>		d. STREET ADDRESS <u>616 Coleraine Road</u>	
3. NAME OF DECEASED (Type or print) <u>WARREN-MELLOR SHAWEN</u>		4. DATE OF DEATH <u>Sept 29 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 30, 1885</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telegrapher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B.O.R.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>Belton Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel M. Shawen</u>		14. MOTHER'S MAIDEN NAME <u>Josephine L. Gosnell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-09-0035</u>	
17. INFORMANT <u>Blanche B. Shawen</u>		Address <u>616 Coleraine Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary sclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 yrs.</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-21-1946</u> to <u>9-29-1958</u> , that I last saw the deceased alive on <u>9-27-1958</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Baltimore, Md.</u> DATE SIGNED <u>9-29-58</u>			
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u>		M.D. <u>6209 E. Edmondson Road</u>	
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>		<u>Baltimore - 28, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 1-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Geipel</u>		ADDRESS <u>5311 Edmondson Ave</u>	
24a. REC'D BY REGISTRAR <u>OCT 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>William P. Howard</u>	

CERTIFICATE OF DEATH

1930

<p>NAME OF DECEASED WALTER NELSON SHAWEN</p>	
<p>AGE 24</p>	<p>SEX Male</p>
<p>DATE OF BIRTH 1906</p>	<p>PLACE OF BIRTH [illegible]</p>
<p>DATE OF DEATH 1930</p>	
<p>PLACE OF DEATH [illegible]</p>	
<p>CAUSE OF DEATH [illegible]</p>	
<p>DIAGNOSIS [illegible]</p>	
<p>DATE OF EXAMINATION 1930</p>	
<p>PLACE OF EXAMINATION [illegible]</p>	
<p>SIGNATURE OF PHYSICIAN [illegible]</p>	
<p>SIGNATURE OF REGISTRAR [illegible]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9977

CERTIFICATE OF DEATH

09967

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Arm		c. LENGTH OF STAY IN 1b 40 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 400 Belair Rd.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Arm	
3. NAME OF DECEASED (Type or print) First Hazel Middle M. Last Shipley		4. DATE OF DEATH Month Sept. Day 2 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1909
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Unknown Sanders		14. MOTHER'S MAIDEN NAME Unknown Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Earl B. Shipley		Address Glen Arm, Md. Box 400 Belair Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 416 X DUE TO Mural thrombus + Congestive heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatic heart disease DUE TO (c) Rheumatic heart disease		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 17 Sept., 1957 , to 2 Sept., 1958 , that I last saw the deceased alive on 9-2 , 19 58 , and that death occurred at 2 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE George D. Edwards		ADDRESS (Street, city or town, state) 9660 Belair Rd. Baltimore Md	
PHYSICIAN'S NAME (Type) George D. Edwards		DATE SIGNED 9-3-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 5, 1958	
22c. NAME OF CEMETERY OR CREMATORY St. Michael's Lutheran		22d. LOCATION (City, town, or county) (State) Belair Rd. - Perry Hall Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lashun Funeral Home		24a. REC'D BY REGISTRAR DATE SEP 5 '58	
ADDRESS 7401 Belair Rd.		24b. REGISTRAR'S SIGNATURE Carlton L. Harris	

CERTIFICATE OF DEATH

1912

PLACE OF DEATH		DATE OF DEATH	
BALTIMORE		JAN 10 1912	
NAME OF DECEASED		AGE	
JAMES J. JONES		35	
SEX		MARRIAGE	
Male		Married	
RACE		RELIGION	
White		Roman Catholic	
EDUCATION		OCCUPATION	
High School		Carpenter	
PREVIOUS ILLNESS		CAUSE OF DEATH	
None		Heart Disease	
DATE OF ONSET		PLACE OF BURIAL	
Jan 5, 1912		St. Mary's Cemetery	
NAME OF FUNERAL HOME		NAME OF MINISTER	
John J. Jones		Rev. J. J. Jones	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
James J. Jones		John J. Jones, John J. Jones	
DATE OF SIGNATURE		DATE OF SIGNATURE	
Jan 10, 1912		Jan 10, 1912	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09968

9978

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>		c. LENGTH OF STAY IN 1b <u>29 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Leanna</u> Middle <u>Shipley</u> Last <u>Shipley</u>		4. DATE OF DEATH Month <u>September</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 3, 1866</u>
9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter Henery Eyler</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Ellen Metz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Raymond Shipley</u>		Address <u>Maryland, Pikesville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> DUE TO <u>1 yr.</u> (c) <u>Gen. Art. Sclerosis</u> DUE TO <u>5 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 9th, 1953</u> to <u>Sept. 3rd, 1958</u> , that I last saw the deceased alive on <u>Sept. 2nd, 1958</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James A. Miller, M.D.</u>		DATE SIGNED <u>9/4/58</u>	
PHYSICIAN'S NAME (Type) <u>James A. Miller, M.D.</u>		ADDRESS (Street, city or town, state) <u>1331 Reister Rd., Pikesville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 5, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Randallstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Gurell</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 8 '58</u>	
ADDRESS <u>Pikesville 8, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hound</u>	

CERTIFICATE OF DEATH

1923

FILE NO.

DATE OF DEATH

PLACE

CAUSE OF DEATH

DECEASED'S NAME

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DECEASED'S NAME

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

9979

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print) <i>Edna J. Shocket</i>			2. DATE OF DEATH <i>Sept 6, 1958</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore County</i>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>BALTO.</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Professional House</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> PIKESVILLE		
c. Length of stay in Baltimore <i>55 Yrs</i>			D. STREET ADDRESS (If rural, give location) <i>3917 Clarks Lane</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>1893</i>	9. AGE (In years last birthday) <i>65</i>	If Under 1 Year Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Rev. W. P. Lee</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		
11. BIRTHPLACE (State or foreign country) <i>Russia</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Samuel Kegan</i>			14. MOTHER'S MAIDEN NAME <i>Sarah Katy</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>1195 Harlan</i>		
17. INFORMANT <i>Mrs. Sydney Rosenfeld</i>			ADDRESS <i>1195 Harlan</i>		

18. <i>170x</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Generalized Carcinomatosis</i>		<i>10 yrs</i>
ANTECEDENT CAUSES		(B) <i>Carcinoma of Breast</i>		<i>16 mo</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C)		

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO CAUSE OF DEATH. <i>ENTER IN</i>	19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21D. TIME PART II OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	

22. I certify that (I) (this hospital) attended the deceased from *Oct 6* 19 *46* to *Sept 6* 19 *58*, that (I) (we) last saw the deceased alive on *Sept 6* 19 *58*, and that death occurred at *11 A.* m., from the causes and on the date stated above.

23A. SIGNATURE <i>Samuel J. Schwartz</i>	23B. ADDRESS <i>2320 Eastland Place</i>	23C. DATE SIGNED <i>9/6/58</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>Sept 7/58</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Midway Road</i>
24D. LOCATION (City, town, or county) <i>Balto, Md.</i>	(State)	25. FUNERAL DIRECTOR <i>1124 26th North Ave</i>
DA DECEASED BY LOCAL REGISTRAR <i>SEP 7 1958</i>	REGISTRAR'S SIGNATURE <i>John A. Williams</i>	ADDRESS <i>1124 26th North Ave</i>

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE INK—DO NOT USE A BALL POINT PEN. Every item of information is carefully supplied. Physicians: please write the causes of death clearly and legibly. HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9980

CERTIFICATE OF DEATH

09970

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) 9. STATE <i>Maryland</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>White Marsh</i>		c. LENGTH OF STAY IN 1b <i>10 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ✓		d. STREET ADDRESS <i>1</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>GEORGE - H - SIBLE</i> First Middle Last		4. DATE OF DEATH <i>Sept 18 1958</i> Month Day Year	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 10-1884</i>
9. AGE (In years last birthday) <i>74</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Laborer</i>	
11. BIRTHPLACE (State or foreign country) <i>Reuma</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Thomas Sible</i>		14. MOTHER'S MAIDEN NAME <i>Gillie Koontz</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>194-14-4187</i>	
17. INFORMANT <i>Isabel Sible - White Marsh Md</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro Vascular accident</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Cardio-Vascular disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i> <i>2 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept 17, 1958</i> , to <i>Sept 18, 1958</i> , that I lost s/he the deceased alive on <i>Sept 18, 1958</i> , and that death occurred at <i>5 P.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W B Baumgardner</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>Balto 6 Md</i> <i>9/19/58</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<i>Burial</i>		<i>9-22-58</i>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Shiloh</i>		<i>Annall Co Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edna C. Tipton</i>		ADDRESS <i>Hampstead Md</i>	
24a. REC'D BY REGISTRAR DATE <i>SEP 23 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kane</i>	

9981

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Howard				c. LENGTH OF STAY IN 1b 6 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS 936 Chesaco Avenue			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle H. Last SIMMONS				4. DATE OF DEATH Month September Day 5 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25, 1881	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector of Air Brakes		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Marysville, Kansas		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George A. Simmons				14. MOTHER'S MAIDEN NAME Mary E. Rushlow			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Philippine		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CEREBRAL THROMBOSIS DUE TO (c) GENERALIZED ARTERIOSCLEROSIS INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 4 YEARS 15 YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PYELONEPHRITIS 491x							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that x attended the deceased from August 30, 1958 , to Sept. 5, 1958 , and that death occurred at 6:55A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, FORT HOWARD, MARYLAND 9/5/58							
ACTUAL SIGNATURE Irving Freeman M.D. VAH, FORT HOWARD, MARYLAND							
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service, VAH, Fort Howard, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/8/58		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE James J. Bruzdinski				ADDRESS 1407 Eastern Ave. Baltimore, Maryland		24a. REC'D BY REGISTRAR DATE SEP 9 '58	
				24b. REGISTRAR'S SIGNATURE Arthur E. Huns			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9982 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dis. No. **60972**

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glendale		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glendale		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6613 Loch Hill Road				d. STREET ADDRESS 6613 Loch Hill Rd.			
3. NAME OF DECEASED (Type or print) First KATHERINE MARIE Middle SKUHRVY Last				4. DATE OF DEATH September 23 19 58 Month Day Year			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 16, 1873	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Louise Smith, daughter, above Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis 10 yrs DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	Month, Day, Year 19 58	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore, Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles F. O'Donnell				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Charles F. O'Donnell				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/27/58		22c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek				ADDRESS 3331 Brehms Lane		24a. REC'D BY REGISTRAR SEP 26 '58 DATE	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained at your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

09973

9842

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe 51	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1708 Rittenhouse Ave.		d. STREET ADDRESS 1708 Rittenhouse Ave.	
3. NAME OF DECEASED (Type or print) Anna M. Smith		4. DATE OF DEATH Month September Day 24 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 28, 1887
9. AGE (In years last birthday) yrs. 71		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer		10b. KIND OF BUSINESS OR INDUSTRY Distillery	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Baker		14. MOTHER'S MAIDEN NAME Helen Haas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-05-2482	
17. INFORMANT Henry Smith		Address 1708 Rittenhouse Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x Acute Cardiac failure DUE TO (b) Cardiovascular and disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. Diabetic Mel DUE TO (c) 3x4yr			INTERVAL BETWEEN ONSET AND DEATH 7yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1957 , 19____, to Sept 24, 1958 , that I last saw the deceased alive on Sept 19, 1958 , and that death occurred at 8:20 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE GEO. S. M. KIEFFER		M.D. 1010 Leaden	
PHYSICIAN'S NAME (Type) GEO. S. M. KIEFFER		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/26/58	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Ambrose, Inc 1328 Sulphur Spring Rd		24a. REC'D BY REGISTRAR DATE SEP 26 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Frank

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF PHYSICIAN

NAME OF MINISTER

NAME OF CLERGYMAN

SIGNATURE OF PHYSICIAN

SIGNATURE OF MINISTER

SIGNATURE OF CLERGYMAN

NAME OF DECEASED

AGE

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

DATE OF BURIAL

PLACE OF BURIAL

NAME OF PHYSICIAN

NAME OF MINISTER

NAME OF CLERGYMAN

SIGNATURE OF PHYSICIAN

SIGNATURE OF MINISTER

SIGNATURE OF CLERGYMAN

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

DATE OF BURIAL

PLACE OF BURIAL

NAME OF PHYSICIAN

NAME OF MINISTER

NAME OF CLERGYMAN

SIGNATURE OF PHYSICIAN

SIGNATURE OF MINISTER

SIGNATURE OF CLERGYMAN

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

DATE OF BURIAL

PLACE OF BURIAL

NAME OF PHYSICIAN

NAME OF MINISTER

NAME OF CLERGYMAN

SIGNATURE OF PHYSICIAN

SIGNATURE OF MINISTER

SIGNATURE OF CLERGYMAN

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

DATE OF BURIAL

PLACE OF BURIAL

NAME OF PHYSICIAN

NAME OF MINISTER

NAME OF CLERGYMAN

SIGNATURE OF PHYSICIAN

SIGNATURE OF MINISTER

SIGNATURE OF CLERGYMAN

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

DATE OF BURIAL

PLACE OF BURIAL

NAME OF PHYSICIAN

NAME OF MINISTER

NAME OF CLERGYMAN

SIGNATURE OF PHYSICIAN

SIGNATURE OF MINISTER

SIGNATURE OF CLERGYMAN

9983

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 26 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. STREET ADDRESS 415 Race Street	
3. NAME OF DECEASED (Type or print) First EMORY Middle C. Last SMULLEN		4. DATE OF DEATH Month September Day 29 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 5, 1891
9. AGE (In years last birthday) yrs. 67		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Basket Maker		10b. KIND OF BUSINESS OR INDUSTRY Basketwork	
11. BIRTHPLACE (State or foreign country) Wicomico Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Lewis W. Smullen		14. MOTHER'S MAIDEN NAME Mary E. Tarr	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mr. Wm. T. Smullen (Nephew)		Salisbury, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA AND CONGESTION 241X DUE TO STATUS ASTHMATICUS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operation - 9/29/58 - Transurethral Resection of Prostate		INTERVAL BETWEEN ONSET AND DEATH 3 HOURS 3 HOURS	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 3, 1958 , to September 29, 1958 , and that death occurred at 1:10 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Chien Wei Lan		ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND	
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.		DATE SIGNED 9/30/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 2, 1958	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Holloway & Co.		ADDRESS Salisbury, Maryland	
24a. REC'D BY REGISTRAR OCT 2 '58		24b. REGISTRAR'S SIGNATURE Arthur L. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be received by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

CERTIFICATE OF DEATH

09975

Reg. Dist. No.

9984

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard, Maryland</u>		c. LENGTH OF STAY IN 1b <u>3 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		3701.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>1918 W. Mulberry Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALEXANDER</u> <u>----</u> <u>SOLLERS</u>				4. DATE OF DEATH Month Day Year <u>September</u> <u>9</u> <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 31, 1890</u>		9. AGE (In years last birthday) <u>67</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Family</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Sollers</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Tate</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Clin. Records, Vet. Adm. Hospital, Ft. Howard, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF PENIS WITH METASTASIS TO LUNGS</u> <u>179.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>179.0</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u> <u>BRONCHOPNEUMONIA</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1+ YEARS</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>September 6, 1958</u> , to <u>September 9, 1958</u> , that he was the deceased and that death occurred at <u>10:30 A. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Chien Wei Lan</u> M.D.				PHYSICIAN'S NAME (Type) <u>CH IEN WEI LAN, M. D.</u> <u>VAH, Fort Howard, Maryland</u> <u>9/9/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/12/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arlington S. Phillips Funeral Director.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9989 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11093

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Pikesville, Md.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				/ d. STREET ADDRESS 7021 Plymouth Road			
3. NAME OF DECEASED (Type or print) First Otto Middle George Last Steinmetz				4. DATE OF DEATH Month Sept. Day 30 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 21, 1881	
9. AGE (In years last birthday) 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis G. Steinmetz				14. MOTHER'S MAIDEN NAME Catherine Staub			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Anna B. Callahan, 7022 Plymouth Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Acute Cardiac Decompensation 443X DUE TO Decompensated Hypertensive C-V Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							INTERVAL BETWEEN ONSET AND DEATH 6 hrs. 6 mos.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month. Day. Year Hour a. m. none p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE D. D. Caples				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) D. D. Caples, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Oct. 2, 1958		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell, Pikesville, Md.				24a. REC'D BY REGISTRAR DATE OCT 8 '58		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	
22d. LOCATION (City, town, or county) (State) Baltimore, Maryland				DATE SIGNED 10-1-58			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. as its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9835 **CERTIFICATE OF DEATH**

09976

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY Baltimore MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) Dundalk
TOWN Dundalk
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Md COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) Dundalk
TOWN Dundalk
STREET ADDRESS (If rural give location) 2605 Yorkway

3. NAME OF DECEASED
(Type or Print)

(First) Carole (Middle) Lucille (Last) Stephens

4. DATE OF DEATH (Month) (Day) (Year)

Sept 26/58 19

5. SEX

Female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

single

8. DATE OF BIRTH

Sept 19 1941

9. AGE last birthday

17 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Theodore Stephens

14. MOTHER'S MAIDEN NAME

Emily Camp

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS

Mrs Emily Stephens 2605 Yorkway

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

754.5 IMMEDIATE CAUSE (A) myocardial Failure
ANTECEDENT CAUSE(S) DUE TO (B) Congenital Heart Disease
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)

INTERVAL BETWEEN ONSET AND DEATH

24 hours

Lifetime

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9 Jan 58, 1958, to 26 Sept 58, 1958, that I last saw the deceased alive on 26 Sept 58, 1958, and that death occurred at 2:40 P.M. from the causes and on the date stated above.

SIGNATURE

W. Morrison

M.D.

3 Kenshy Rd, Balto 22

ADDRESS (Street, city, town, state)

DATE SIGNED

29 Sept 58

23. BURIAL, CREMATION, REMOVAL (SPECIFY)
burial

DATE THEREOF

Sept 30/58

NAME OF CEMETERY OR CREMATORY

Oak Lawn Cemetery

LOCATION (City, town, or county)

Baltimore Co

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

Arthur L. Kneass

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Ullrich Funeral Home 2112 Dundalk Ave

DATE OCT 2 '58

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH 9986				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto</u> MARYLAND				STATE <u>Md</u> COUNTY <u>Balto</u>			
CITY (If outside corporate limits, write RURAL or end give nearest town) TOWN <u>Woodstock</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Woodstock</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hernwood Road</u>				STREET ADDRESS (If rural give location) <u>Hernwood Road</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>George</u> (Middle) <u>L.</u> (Last) <u>Strohmer</u>				4. DATE OF DEATH (Month) <u>9</u> (Day) <u>25</u> (Year) <u>1958</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 17, 1883</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Co; Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Strohmer</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Wickert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>218-124287</u>		17. INFORMANT & ADDRESS <u>George J. Strohmer Hernwood Road</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443x IMMEDIATE CAUSE (A) <u>Cerebral Vascular accident -</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive C.V. Disease - severe</u>				<u>10 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>APRIL 1, 1958</u> , to <u>APR 25, 1958</u> , that I last saw the deceased alive on <u>APR 25, 1958</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Thomas E. Wheeler</u>		M.D.		ADDRESS (Street, city, town, state) <u>3601 Clifmar Road Balto. 7, Md.</u>		DATE SIGNED <u>9/25/58</u> (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-29-58</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Family Church Cemetery</u>		LOCATION (City, town, or county) <u>Harrisonville, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>OCT 1 '58</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byers</u>		ADDRESS <u>8728 Liberty Road Randa 11stown Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after the bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled in by the funeral director, the third copy of certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

State of Mass.

1. Name of deceased

2. Date of death

3. Place of death

4. Age

5. Sex

6. Occupation

7. Cause of death

8. Date of burial

9. Place of burial

10. Signature of physician

11. Signature of registrar

12. Signature of informant

13. Signature of witness

14. Signature of registrar

15. Signature of informant

16. Signature of witness

17. Signature of registrar

18. Signature of informant

19. Signature of witness

20. Signature of registrar

21. Signature of informant

22. Signature of witness

23. Signature of registrar

24. Signature of informant

25. Signature of witness

26. Signature of registrar

27. Signature of informant

28. Signature of witness

29. Signature of registrar

30. Signature of informant

31. Signature of witness

32. Signature of registrar

INSTRUCTIONS

TO VALUERS, REGISTRARS OR INFORMANTS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9987

CERTIFICATE OF DEATH

09978

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 CATONSVILLE</u>		d. STREET ADDRESS <u>5444 ADDINGTON RD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5444 ADDINGTON RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>PETER</u> Middle <u>PAUL</u> Last <u>TARSIA</u>		4. DATE OF DEATH Month <u>SEPT.</u> Day <u>18</u> Year <u>1958</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 3, 1911</u>
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN, AMERICAN CHICLE CO.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BALTO. MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANK TARSIA</u>		14. MOTHER'S MAIDEN NAME <u>ROSE BIANDO</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>213-03-3987</u>	
17. INFORMANT <u>MRS CATHERINE M. TARSIA,</u> <u>5444 ADDINGTON RD. CATONSVILLE MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u> </u> 19 <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 1946</u> to <u>Sept. 18, 1958</u> , that I last saw the deceased alive on <u>Aug 15, 1958</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3325 Frederick Ave</u> DATE SIGNED <u> </u> ACTUAL SIGNATURE <u>J. C. Pounds</u> M.D. <u> </u> PHYSICIAN'S NAME (Type) <u>J. C. Pounds</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT. 22/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BALTO. NATIONAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WITZKE FUNERAL DIR. 4101 EDMONDSON</u>		ADDRESS <u>AVE.</u> 24a. REC'D BY REGISTRAR DATE <u>SEP 24 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knecht</u>			

MEDICAL CERTIFICATION

9988

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lochearn		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lochearn	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3605 Patterson Ave.		d. STREET ADDRESS 3605 Patterson Ave.	
3. NAME OF DECEASED (Type or print) First WALTER Middle IRVIN Last TAUBER		4. DATE OF DEATH Month Sept. Day 29 Year 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 19, 1891
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician (rtd)		10b. KIND OF BUSINESS OR INDUSTRY Printing	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John F. Tauber		14. MOTHER'S MAIDEN NAME Rebecca J. Herling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) World War I	
17. INFORMANT Mrs. Elevian R. Carter - 3605 Patterson Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral Hemorrhage DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 48 , to Sept. 29, 19 58 , that I last saw the deceased alive on Sept. 29, 19 58 , and that death occurred at 10 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Isidore I. Levy		DATE SIGNED 10-1-58	
PHYSICIAN'S NAME (Type) Isidore I. Levy		ADDRESS (Street, city or town, state) 2322 Canton Place	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/2/58	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Park		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto.		24a. REC'D BY REGISTRAR OCT 1 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9989

CERTIFICATE OF DEATH

09981

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural-Freeland</i>		c. LENGTH OF STAY IN 1b <i>50yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Bentley Springs Rd.</i>		d. STREET ADDRESS <i>Bentley Springs Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>James Lawrence Thomas.</i>		4. DATE OF DEATH <i>Sept. 6, 1958.</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 27, 1895</i>
9. AGE (In years lost birth yrs.) <i>62.</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Trackman</i>		12. KIND OF BUSINESS OR INDUSTRY <i>P. R. R.</i>	
13. FATHER'S NAME <i>Mathias Thomas.</i>		14. MOTHER'S MAIDEN NAME <i>Hester Keys.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <i>Yes.</i>		16. SOCIAL SECURITY NO. <i>717-07-6767</i>	
17. INFORMANT <i>Mrs. Evelyn Thomas, Freeland Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>one year</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>November 5, 1957</i> , to <i>9-5, 1958</i> , that I last saw the deceased alive on <i>Sept. 5, 1958</i> , and that death occurred at <i>8:30 P. M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Louis Schatanoff</i> M.D.		ADDRESS (Street, city or town, state) <i>New Freedom, PA</i>	
DATE SIGNED <i>9-8-58</i>			
PHYSICIAN'S NAME (Type) <i>LOUIS SCHATANOFF</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Sept. 9, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>New Freedom Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>New Freedom Pa.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert Hartenstein</i>		ADDRESS <i>New Freedom, Pa.</i>	
24a. REC'D BY REGISTRAR <i>SEP 9 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]	
5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]		7. MARITAL STATUS [Faint text]		8. CAUSE OF DEATH [Faint text]	
9. MEDICAL HISTORY [Faint text]		10. PRESENT ILLNESS [Faint text]		11. DATE OF DEATH [Faint text]		12. TIME OF DEATH [Faint text]	
13. SIGNATURE OF PHYSICIAN [Faint text]		14. SIGNATURE OF REGISTRAR [Faint text]		15. SIGNATURE OF WITNESS [Faint text]		16. SIGNATURE OF DECEASED [Faint text]	
17. PLACE OF DEATH [Faint text]		18. PLACE OF BURIAL [Faint text]		19. DATE OF BURIAL [Faint text]		20. TIME OF BURIAL [Faint text]	
21. SIGNATURE OF BURIAL OFFICIAL [Faint text]		22. SIGNATURE OF DECEASED [Faint text]		23. SIGNATURE OF WITNESS [Faint text]		24. SIGNATURE OF DECEASED [Faint text]	
25. SIGNATURE OF DECEASED [Faint text]		26. SIGNATURE OF WITNESS [Faint text]		27. SIGNATURE OF DECEASED [Faint text]		28. SIGNATURE OF WITNESS [Faint text]	
29. SIGNATURE OF DECEASED [Faint text]		30. SIGNATURE OF WITNESS [Faint text]		31. SIGNATURE OF DECEASED [Faint text]		32. SIGNATURE OF WITNESS [Faint text]	
33. SIGNATURE OF DECEASED [Faint text]		34. SIGNATURE OF WITNESS [Faint text]		35. SIGNATURE OF DECEASED [Faint text]		36. SIGNATURE OF WITNESS [Faint text]	
37. SIGNATURE OF DECEASED [Faint text]		38. SIGNATURE OF WITNESS [Faint text]		39. SIGNATURE OF DECEASED [Faint text]		40. SIGNATURE OF WITNESS [Faint text]	
41. SIGNATURE OF DECEASED [Faint text]		42. SIGNATURE OF WITNESS [Faint text]		43. SIGNATURE OF DECEASED [Faint text]		44. SIGNATURE OF WITNESS [Faint text]	
45. SIGNATURE OF DECEASED [Faint text]		46. SIGNATURE OF WITNESS [Faint text]		47. SIGNATURE OF DECEASED [Faint text]		48. SIGNATURE OF WITNESS [Faint text]	
49. SIGNATURE OF DECEASED [Faint text]		50. SIGNATURE OF WITNESS [Faint text]		51. SIGNATURE OF DECEASED [Faint text]		52. SIGNATURE OF WITNESS [Faint text]	
53. SIGNATURE OF DECEASED [Faint text]		54. SIGNATURE OF WITNESS [Faint text]		55. SIGNATURE OF DECEASED [Faint text]		56. SIGNATURE OF WITNESS [Faint text]	
57. SIGNATURE OF DECEASED [Faint text]		58. SIGNATURE OF WITNESS [Faint text]		59. SIGNATURE OF DECEASED [Faint text]		60. SIGNATURE OF WITNESS [Faint text]	
61. SIGNATURE OF DECEASED [Faint text]		62. SIGNATURE OF WITNESS [Faint text]		63. SIGNATURE OF DECEASED [Faint text]		64. SIGNATURE OF WITNESS [Faint text]	
65. SIGNATURE OF DECEASED [Faint text]		66. SIGNATURE OF WITNESS [Faint text]		67. SIGNATURE OF DECEASED [Faint text]		68. SIGNATURE OF WITNESS [Faint text]	
69. SIGNATURE OF DECEASED [Faint text]		70. SIGNATURE OF WITNESS [Faint text]		71. SIGNATURE OF DECEASED [Faint text]		72. SIGNATURE OF WITNESS [Faint text]	
73. SIGNATURE OF DECEASED [Faint text]		74. SIGNATURE OF WITNESS [Faint text]		75. SIGNATURE OF DECEASED [Faint text]		76. SIGNATURE OF WITNESS [Faint text]	
77. SIGNATURE OF DECEASED [Faint text]		78. SIGNATURE OF WITNESS [Faint text]		79. SIGNATURE OF DECEASED [Faint text]		80. SIGNATURE OF WITNESS [Faint text]	
81. SIGNATURE OF DECEASED [Faint text]		82. SIGNATURE OF WITNESS [Faint text]		83. SIGNATURE OF DECEASED [Faint text]		84. SIGNATURE OF WITNESS [Faint text]	
85. SIGNATURE OF DECEASED [Faint text]		86. SIGNATURE OF WITNESS [Faint text]		87. SIGNATURE OF DECEASED [Faint text]		88. SIGNATURE OF WITNESS [Faint text]	
89. SIGNATURE OF DECEASED [Faint text]		90. SIGNATURE OF WITNESS [Faint text]		91. SIGNATURE OF DECEASED [Faint text]		92. SIGNATURE OF WITNESS [Faint text]	
93. SIGNATURE OF DECEASED [Faint text]		94. SIGNATURE OF WITNESS [Faint text]		95. SIGNATURE OF DECEASED [Faint text]		96. SIGNATURE OF WITNESS [Faint text]	
97. SIGNATURE OF DECEASED [Faint text]		98. SIGNATURE OF WITNESS [Faint text]		99. SIGNATURE OF DECEASED [Faint text]		100. SIGNATURE OF WITNESS [Faint text]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please advise the State, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9990

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 Film 233 9-11-58 et

09982

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE MD. b. COUNTY BALTIMORE						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-COCKEYSVILLE		c. LENGTH OF STAY IN 1b						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) OREGON FARMS		1. d. STREET ADDRESS OREGON FARMS						
3. NAME OF DECEASED (Type or print) BERTHA First MAE Middle TURNBAULT Last		4. DATE OF DEATH Month SEPT Day 7 Year 1958						
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1891 9-13-95	9. AGE (In years for birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME PAWEL KENNEDY		14. MOTHER'S MAIDEN NAME ALBRIGHT		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. -	17. INFORMANT Address MRS. CHARLES SPERA, SAME
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 7 YRS		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE William A. Pillsbury				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9-7-58		
EXAMINER'S NAME (Type) WILLIAM A. PILLSBURY				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)		
BURIAL		SEPT. 10, 1958		TRINITY CEMETERY		LONG GREEN, MD.		
22e. FUNERAL DIRECTOR'S SIGNATURE John Burns Sr., Towson, Md.				24a. REC'D BY REGISTRAR DATE SEP 9 1958		24b. REGISTRAR'S SIGNATURE Carlton E. Kneave		

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9991

CERTIFICATE OF DEATH

Reg. Dist. No.

09983

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2321 N. Rolling Rd.				d. STREET ADDRESS 2321 N. Rolling Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Theresa J. von Paris				4. DATE OF DEATH Month Day Year September 14 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 21, 1885	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland	
11. BIRTHPLACE (State or foreign country) USA				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Henry J. Anton				14. MOTHER'S MAIDEN NAME Mary C. Yakel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Bonaventure von Paris-2321 N. Rolling Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, bilateral DUE TO 602X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pylonephritis, bilateral, chronic DUE TO 15 yrs (c) Bilateral Renal Stenosis DUE TO 15 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arthritis, osteo; - Hypertensive C.V. disease 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 1948 to Sept 14, 1958 , that I last saw the deceased alive on September 14, 1958 , and that death occurred at P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4023 Fallsstaff Rd, Balt, Md DATE SIGNED 9-15-58							
ACTUAL SIGNATURE Hyman Schiff M.D.				PHYSICIAN'S NAME (Type) Hyman Schiff M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/18/1958		22c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost-4600 Liberty Heights Ave.				24a. REC'D BY REGISTRAR DATE SEP 17 '58		24b. REGISTRAR'S SIGNATURE Arthur E. Jones	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS		SINGLE	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ALCOHOL	
PREVIOUS TOBACCO		PREVIOUS SMOKE		PREVIOUS WEAPON		PREVIOUS VEHICLE		PREVIOUS AIRCRAFT	
PREVIOUS BOAT		PREVIOUS FISHING		PREVIOUS HUNTING		PREVIOUS CAMPING		PREVIOUS TRAVEL	
PREVIOUS FOREIGN		PREVIOUS DOMESTIC		PREVIOUS LOCAL		PREVIOUS NEIGHBORHOOD		PREVIOUS CITY	
PREVIOUS STATE		PREVIOUS COUNTRY		PREVIOUS CONTINENT		PREVIOUS WORLD		PREVIOUS UNIVERSE	
PREVIOUS GALAXY		PREVIOUS COSMOS		PREVIOUS UNIVERSE		PREVIOUS TIME		PREVIOUS SPACE	
PREVIOUS MATTER		PREVIOUS ENERGY		PREVIOUS FORCE		PREVIOUS MOTION		PREVIOUS CHANGE	
PREVIOUS BEING		PREVIOUS DOING		PREVIOUS HAVING		PREVIOUS KNOWING		PREVIOUS FEELING	
PREVIOUS THINKING		PREVIOUS BELIEVING		PREVIOUS TRUSTING		PREVIOUS LOVING		PREVIOUS HOPING	
PREVIOUS DREAMING		PREVIOUS IMAGINING		PREVIOUS REMEMBERING		PREVIOUS FORGETTING		PREVIOUS RECALLING	
PREVIOUS RECOGNIZING		PREVIOUS IDENTIFYING		PREVIOUS DESCRIBING		PREVIOUS EXPLAINING		PREVIOUS JUSTIFYING	
PREVIOUS DEFENDING		PREVIOUS ATTACKING		PREVIOUS FIGHTING		PREVIOUS WINNING		PREVIOUS LOSING	
PREVIOUS SUCCEEDING		PREVIOUS FAILING		PREVIOUS TRYING		PREVIOUS GIVING		PREVIOUS RECEIVING	
PREVIOUS OFFERING		PREVIOUS DEMANDING		PREVIOUS PROMISING		PREVIOUS BREAKING		PREVIOUS KEEPING	
PREVIOUS HOLDING		PREVIOUS LETTING		PREVIOUS ALLOWING		PREVIOUS DENYING		PREVIOUS ADMITTING	
PREVIOUS CONCEALING		PREVIOUS REVEALING		PREVIOUS HIDING		PREVIOUS SHOWING		PREVIOUS DISPLAYING	
PREVIOUS EXHIBITING		PREVIOUS PERFORMING		PREVIOUS PARTICIPATING		PREVIOUS OBSERVING		PREVIOUS WATCHING	
PREVIOUS LISTENING		PREVIOUS TALKING		PREVIOUS WRITING		PREVIOUS READING		PREVIOUS STUDYING	
PREVIOUS TEACHING		PREVIOUS LEARNING		PREVIOUS WORKING		PREVIOUS PLAYING		PREVIOUS RESTING	
PREVIOUS SLEEPING		PREVIOUS WAKING		PREVIOUS EATING		PREVIOUS DRINKING		PREVIOUS SMOKING	
PREVIOUS TOBACCO		PREVIOUS SMOKE		PREVIOUS WEAPON		PREVIOUS VEHICLE		PREVIOUS AIRCRAFT	
PREVIOUS BOAT		PREVIOUS FISHING		PREVIOUS HUNTING		PREVIOUS CAMPING		PREVIOUS TRAVEL	
PREVIOUS FOREIGN		PREVIOUS DOMESTIC		PREVIOUS LOCAL		PREVIOUS NEIGHBORHOOD		PREVIOUS CITY	
PREVIOUS STATE		PREVIOUS COUNTRY		PREVIOUS CONTINENT		PREVIOUS WORLD		PREVIOUS UNIVERSE	
PREVIOUS GALAXY		PREVIOUS COSMOS		PREVIOUS UNIVERSE		PREVIOUS TIME		PREVIOUS SPACE	
PREVIOUS MATTER		PREVIOUS ENERGY		PREVIOUS FORCE		PREVIOUS MOTION		PREVIOUS CHANGE	
PREVIOUS BEING		PREVIOUS DOING		PREVIOUS HAVING		PREVIOUS KNOWING		PREVIOUS FEELING	
PREVIOUS THINKING		PREVIOUS BELIEVING		PREVIOUS TRUSTING		PREVIOUS LOVING		PREVIOUS HOPING	
PREVIOUS DREAMING		PREVIOUS IMAGINING		PREVIOUS REMEMBERING		PREVIOUS FORGETTING		PREVIOUS RECALLING	
PREVIOUS RECOGNIZING		PREVIOUS IDENTIFYING		PREVIOUS DESCRIBING		PREVIOUS EXPLAINING		PREVIOUS JUSTIFYING	
PREVIOUS DEFENDING		PREVIOUS ATTACKING		PREVIOUS FIGHTING		PREVIOUS WINNING		PREVIOUS LOSING	
PREVIOUS SUCCEEDING		PREVIOUS FAILING		PREVIOUS TRYING		PREVIOUS GIVING		PREVIOUS RECEIVING	
PREVIOUS OFFERING		PREVIOUS DEMANDING		PREVIOUS PROMISING		PREVIOUS BREAKING		PREVIOUS KEEPING	
PREVIOUS HOLDING		PREVIOUS LETTING		PREVIOUS ALLOWING		PREVIOUS DENYING		PREVIOUS ADMITTING	
PREVIOUS CONCEALING		PREVIOUS REVEALING		PREVIOUS HIDING		PREVIOUS SHOWING		PREVIOUS DISPLAYING	
PREVIOUS EXHIBITING		PREVIOUS PERFORMING		PREVIOUS PARTICIPATING		PREVIOUS OBSERVING		PREVIOUS WATCHING	
PREVIOUS LISTENING		PREVIOUS TALKING		PREVIOUS WRITING		PREVIOUS READING		PREVIOUS STUDYING	
PREVIOUS TEACHING		PREVIOUS LEARNING		PREVIOUS WORKING		PREVIOUS PLAYING		PREVIOUS RESTING	
PREVIOUS SLEEPING		PREVIOUS WAKING		PREVIOUS EATING		PREVIOUS DRINKING		PREVIOUS SMOKING	

STATE OF MINNESOTA
COUNTY OF []
CITY OF []
DATE OF DEATH []
TIME OF DEATH []
PLACE OF DEATH []
CAUSE OF DEATH []
MANNER OF DEATH []
OCCUPATION []
EDUCATION []
RELIGION []
MARITAL STATUS []
PREVIOUS ILLNESS []
PREVIOUS SURGERY []
PREVIOUS TRAUMA []
PREVIOUS DRUGS []
PREVIOUS ALCOHOL []
PREVIOUS TOBACCO []
PREVIOUS SMOKE []
PREVIOUS WEAPON []
PREVIOUS VEHICLE []
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PREVIOUS LOSING []
PREVIOUS SUCCEEDING []
PREVIOUS FAILING []
PREVIOUS TRYING []
PREVIOUS GIVING []
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PREVIOUS OFFERING []
PREVIOUS DEMANDING []
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PREVIOUS LETTING []
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PREVIOUS DENYING []
PREVIOUS ADMITTING []
PREVIOUS CONCEALING []
PREVIOUS REVEALING []
PREVIOUS HIDING []
PREVIOUS SHOWING []
PREVIOUS DISPLAYING []
PREVIOUS EXHIBITING []
PREVIOUS PERFORMING []
PREVIOUS PARTICIPATING []
PREVIOUS OBSERVING []
PREVIOUS WATCHING []
PREVIOUS LISTENING []
PREVIOUS TALKING []
PREVIOUS WRITING []
PREVIOUS READING []
PREVIOUS STUDYING []
PREVIOUS TEACHING []
PREVIOUS LEARNING []
PREVIOUS WORKING []
PREVIOUS PLAYING []
PREVIOUS RESTING []
PREVIOUS SLEEPING []
PREVIOUS WAKING []
PREVIOUS EATING []
PREVIOUS DRINKING []
PREVIOUS SMOKING []

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9992 Items 7-8 File # 0234 9/20/58 gsj
CERTIFICATE OF DEATH

Reg. Dist. No. 09984

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b <u>3 Vol-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>133 Slide Ave Prof. House</u>		d. STREET ADDRESS <u>3309 Towhataw Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>ROSA</u> Middle <u>WALLER</u> Last <u>WALLER</u>		4. DATE OF DEATH Month <u>9</u> Day <u>17</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1887</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>17</u>	IF UNDER 24 HRS. Hours <u>17</u> Min. <u>15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Austria</u>
13. FATHER'S NAME <u>Harry</u>		14. MOTHER'S MAIDEN NAME <u>Rachael</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Max Waller</u>	
17. INFORMANT <u>Max Waller</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug 29</u> , 19 <u>58</u> , to <u>Sept 17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 17</u> , 19 <u>58</u> , and that death occurred at <u>8:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harvey S. Green, Jr.</u>		ADDRESS (Street, city or town, state) <u>Pikesville 8, Md</u>	
PHYSICIAN'S NAME (Type) <u></u>		DATE SIGNED <u>Sept 18, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>9-18-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Beth T. Felon</u>	22d. LOCATION (City, town or county) (State) <u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis One 2100 Eutaw Place</u>		24a. REC'D BY REGISTRAR <u>SEP 19 58</u>	
ADDRESS <u></u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		DISEASE OR INJURY	
AGE		SEX	
RACE		RELIGION	
BIRTH DATE		BIRTH PLACE	
MARRIAGE DATE		MARRIAGE PLACE	
EDUCATION		OCCUPATION	
PREVIOUS ILLNESS		TREATMENT	
HISTORY		FAMILY HISTORY	
PHYSICAL EXAMINATION		LABORATORY EXAMINATION	
PATHOLOGICAL FINDINGS		MICROSCOPIC FINDINGS	
GROSS FINDINGS		HISTOLOGICAL FINDINGS	
DIAGNOSIS		TREATMENT	
PROGNOSIS		FOLLOW-UP	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

9993

CERTIFICATE OF DEATH

09985

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md				c. LENGTH OF STAY IN 1b 28 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 54 E. Hill St.			
3. NAME OF DECEASED (Type or print) First HARRY Middle G Last WALTERS				4. DATE OF DEATH Month September Day 12 Year 19 58			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 21, 1888	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months 70 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman			10b. KIND OF BUSINESS OR INDUSTRY Railroad Co		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME Samuel S. Walters				14. MOTHER'S MAIDEN NAME Mary E. Green			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 601X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYDRONEPHROSIS AND CHRONIC PYELONEPHRITIS DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH UNKNOWN							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. VA 19 p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 15 , 19 58 , to September 12 19 58 , and that death occurred at 10:45 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Chien Wei Lan				ADDRESS (Street, city or town, state) VAH Ft. Howard, Md			
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.				DATE SIGNED 9/12/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/16/58		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Denny Inc. Light & Montgomery Sts. Balto. Md				24a. REC'D BY REGISTRAR SEP 16 '58		24b. REGISTRAR'S SIGNATURE Arthur L. House	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mount Washington</u>				c. LENGTH OF STAY IN 1b <u>9</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Victor E. Warner</u>				4. DATE OF DEATH Month Day Year <u>September 22, 1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-23-1896</u>		9. AGE (In years last birthday) yrs. <u>62</u>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Route Carrier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sunpapers</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ephraim W. Warner</u>				14. MOTHER'S MAIDEN NAME <u>Sarah M. Weaver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>218-32-3021</u>		17. INFORMANT Address <u>Mrs. Mildred Hummel, Old Pimlico Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u> <u>2 years.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>3/14/55</u> , to <u>Sept 20th</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept. 12th</u> , 19 <u>58</u> , and that death occurred at <u>2 P.</u> M., from the causes and on the date stated above							
ACTUAL SIGNATURE <u>James A. Miller M.D.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>1331 Reisterstown Rd, Pikesville, Md. 9/24/58</u>					
PHYSICIAN'S NAME (Type) <u>James A. Miller, M.D.</u>		ADDRESS <u>Reisterstown Road, Pikesville 8, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 26, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. [Signature]</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

FOR STATE
HEALTH DEPT.

Item 18 Film 34 10-17-58 ans										MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										09986																																							
9995										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.																																							
1. PLACE OF DEATH a. COUNTY Baltimore					b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn					c. LENGTH OF STAY IN 1b					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland					b. COUNTY Baltimore																																							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Johnny Cake Rd. near Rolling Road										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																																	
3. NAME OF DECEASED (Type or print) First MELVIN Middle WAYNE Last WATERS					4. DATE OF DEATH Month September Day 21 Year 58					5. SEX Male					6. COLOR OR RACE White					7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH Sept. 1, 1958					9. AGE (In years last birthday) 3 weeks					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					11. BIRTHPLACE (State or foreign country) WASH. D.C.					12. CITIZEN OF WHAT COUNTRY?														
13. FATHER'S NAME										14. MOTHER'S MAIDEN NAME ANNE WATERS										15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)										16. SOCIAL SECURITY NO.										17. INFORMANT Address																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 053.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)																				INTERVAL BETWEEN ONSET AND DEATH																																							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>										20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																																											
ACTUAL SIGNATURE <i>Paul F. Guerin</i>										M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>										ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>										DEPUTY MEDICAL EXAMINER <input type="checkbox"/>										DATE SIGNED 9/22/58																			
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.										22a. BURIAL, CREMATION, REMOVAL (Specify) Burial										22b. DATE THEREOF Sept 25, 1958										22c. NAME OF CEMETERY OR CREMATORY London PARK										22d. LOCATION (City, town, or county) (State) Baltimore Md.																			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Witzke Funeral Directors</i>										4101 Edmondson Ave.										24a. REC'D BY REGISTRAR DATE SEP 29 '58										24b. REGISTRAR'S SIGNATURE <i>William S. Hanna</i>																													

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

A15ME
2/57

— 2 —

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9996

CERTIFICATE OF DEATH

09987

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN 1b 4 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armcast Nursing Home		e. STREET ADDRESS 1224 S. Charles Street	
3. NAME OF DECEASED (Type or print) First Middle Last CATHERINE ELIZABETH WEAVER		4. DATE OF DEATH Month Day Year September 7, 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1875
9. AGE (In years last birthday) yrs. 83		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY at Home	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Philipp Kimmel		14. MOTHER'S MAIDEN NAME Christina Escherich	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT MR. EDWIN C. WEAVER FIDELITY BLDG.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary occlusion + myocardial infarction DUE TO (c) Arterio Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 days 3 mos ? years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Occlusion Right Brachial artery - Cerebral Thrombosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 1954 to September 7, 19 58 , that I last saw the deceased alive on September 19 58 , and that death occurred at 10:58 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE C. Wilbur Stewart		DATE SIGNED 6 E. Rad St Baltimore 2-9/8/58	
PHYSICIAN'S NAME (Type) C. Wilbur Stewart			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 11, 1958	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Sander & Sons, Inc.		ADDRESS Baltimore, Md.	
24a. REC'D BY REGISTRAR SEP 11 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09988

9997

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>301-4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>301-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Lines</u>		d. STREET ADDRESS <u>3412 Dolfeld Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GOLDIE H WEINER</u>		4. DATE OF DEATH Month Day Year <u>9-30-1958</u>	
5. SEX <u>Female</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Saves</u>		14. MOTHER'S MAIDEN NAME <u>Johannah</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Charlotte Patz - same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>492X Pneumonitis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1952</u> to <u>9-30-1958</u> , that I last saw the deceased alive on <u>9-30-1958</u> , and that death occurred at <u>11:50</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stanley R Steinbach</u> M.D.		ADDRESS (Street, city or town, state) <u>3334 Dolfeld Ave Balto 15, Md</u>	
DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>STANLEY R. STEINBACH</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-1-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bnai Israel</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u>		ADDRESS <u>2100 Eastgate Pl</u>	
24a. REC'D BY REGISTRAR <u>ACT 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9998

Item 9 Film G234 10-15-58 at

CERTIFICATE OF DEATH

09989

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION TOWSON CONVALESCENT HOME				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore 9 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3v01-4 d. STREET ADDRESS 2203 Arden Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last FRANCES C. WENSLEY			4. DATE OF DEATH Month Day Year 9 25 1958				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10.26.82	9. AGE (In years less than 1 year) 74 1/2	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) NEW JERSEY			
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME (unknown) Craig				
14. MOTHER'S MAIDEN NAME ALICE CRAIG			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO.			17. INFORMANT Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170x METASTATIC CARCINOMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA OF BREAST DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS 4 YRS					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)			
20f. (City or town)							
21. I certify that I attended the deceased from 9.3 , 19 58 , to 9.25 , 19 58 , that I last saw the deceased alive on 9.24 , 19 58 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10 W. MADISON ST. BALTO., MD DATE SIGNED 9.25.58 ACTUAL SIGNATURE Paul G. Herold M.D. PAUL G. HEROLD, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 9-26-58		22c. NAME OF CEMETERY OR CREMATORY Nutley			
22d. LOCATION (City, town, or county) Nutley, N.J.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc., 1050 York Rd. Towson			24a. REC'D BY REGISTRAR DATE SEP 29 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

CERTIFICATE OF DEATH

8228

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

RELIGION

DATE OF MARRIAGE

DATE OF DEATH

DATE OF BIRTH

DATE OF MARRIAGE

DATE OF DEATH

DATE OF BIRTH

DATE OF MARRIAGE

DATE OF DEATH

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DATE OF MARRIAGE

DATE OF DEATH

DATE OF BIRTH

DATE OF MARRIAGE

DATE OF DEATH

DATE OF BIRTH

DATE OF MARRIAGE

DATE OF DEATH

DATE OF BIRTH

DATE OF MARRIAGE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9999

CERTIFICATE OF DEATH

Reg. Dist. No.

09990

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6902 Beech Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EMMA First WHEELER Middle Last		4. DATE OF DEATH SEPTEMBER 2 19 58 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 8, 1869
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY At Home	
11c. BIRTHPLACE (State or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John J. Schaefer		14. MOTHER'S MAIDEN NAME Margaretha Bauer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Adazell E. Frank		Address 6902 Beech Ave. (6)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-Vascular Hypertensive Disease DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 days 20 yrs. 20 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. f. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb , 19 48 , to Sept. 2 , 19 58 , that I last saw the deceased alive on Sept 1 , 19 58 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Michael J. Dausek M.D. 4636 Belair Road		ADDRESS (Street, city or town, state) Baltimore, Md. DATE SIGNED 9-2-58	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 6, 1958	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lorraine Funeral Home		ADDRESS 7401 Belair Rd.	
24a. REC'D BY REGISTRAR SEP 4 '58		24b. REGISTRAR'S SIGNATURE Charles E. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10000 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
109991
10000
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u> c. LENGTH OF STAY IN 1b <u>44 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>at home</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u> d. STREET ADDRESS <u>507 Melancthon Pl</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Virginia Register Whitcraft</u> DATE OF DEATH Month Day Year <u>Sept-7-1958</u>		4. DATE OF DEATH Month Day Year <u>Sept-7-1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/16-1890</u>
9. AGE (In years last birthday) <u>68</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Ballo. Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Edw C Register</u>	
14. MOTHER'S MAIDEN NAME <u>Bettie Wilson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>H. Whitcraft husband</u> Address <u>Lutherville</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis - 420.1</u> DUE TO (b) <u>Arteriosclerosis, general</u> DUE TO (c) <u>Hypertension</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11/11</u> , 19 <u>57</u> , to <u>7/7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/27</u> , 19 <u>57</u> , and that death occurred at <u>11:15</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bennett A. Stacey</u> M.D.		DATE SIGNED <u>7/13/58</u>	
PHYSICIAN'S NAME (Type) <u>Bennett A. Stacey</u>		ADDRESS (Street, city or town, state) <u>1945 Seminary Ave Lutherville</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>Sept-10-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Louebou</u>	22d. LOCATION (City, town, or county) (State) <u>Ballo 39 Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stewart M. Morris</u> ADDRESS <u>108 W North</u>		24a. REC'D BY REGISTRAR <u>SEP 10 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Phares</u>

10001

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn 7,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town). Woodlawn 7,	
d. NAME OF HOSPITAL (If not in hospital, give street address) 2012 Russell Ave.		d. STREET ADDRESS 2012 Russell Ave	
3. NAME OF DECEASED (Type or print) Hugh Wilson		4. DATE OF DEATH Month Sept. Day 8 Year 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 3, 1886
9. AGE (In years lost birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 7 Days 2 Hours 1 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired School Teacher, Baltimore City		10b. KIND OF BUSINESS OR INDUSTRY City - Maine	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Wilson		14. MOTHER'S MAIDEN NAME Agnes Kerr	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Mary L. Wilson, 2012 Russell Ave.		Address Balto. 7, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon DUE TO (b) Diverticulitis of sigmoid colon DUE TO (c) 7 yrs.		INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 5 - , 19 48 , to Sept. 8 - , 19 58 , that I last saw the deceased alive on Sept. 5 - , 19 58 , and that death occurred at 12:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Earl L. Chambers		ADDRESS (Street, city or town, state) 4108 Liberty St. A. Balto. Md. 9-9-58	
PHYSICIAN'S NAME (Type) Earl L. Chambers		DATE SIGNED 4108 Liberty St. A. Balto. Md. 9-9-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 11/58	22c. NAME OF CEMETERY OR CREMATORY Garden of Faith	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D. 4101		ADDRESS Balto. 29 Md.	
24a. REC'D BY REGISTRAR DATE SEP 10 58		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 22 hours after death.

ST. LOUIS 318

2000

514

Mr. J. H. Wilson, 3015 17th St. N.W.

THE UNIVERSITY OF CHICAGO PRESS

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND
10002 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09993

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO. CO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLE RIVER		c. LENGTH OF STAY IN 1b 54 BALTIMORE #21.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS BOX #584 SUE GROVE RD.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM G. WINTERLING SR.		4. DATE OF DEATH Month Day Year Sept 1 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 17, 1901
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RESTAURANT		10b. KIND OF BUSINESS OR INDUSTRY SELF	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CONSTANTINE WINTERLING		14. MOTHER'S MAIDEN NAME CHRISTINE PROTZMAN.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT EVELYN WINTERLING		Address SAME.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DROWNING 850x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) FELL FROM FISHING BOAT IN MIDDLE RIVER BETWEEN	
20c. TIME OF INJURY Month, Day, Year 9-29 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Middle River		20f. (City or town) (County) (State) Middle River BALTO MD	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE M. B. Davis		DATE SIGNED 9-1-58	
EXAMINER'S NAME (Type) M. B. Davis M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-3-58	
22c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEM.		22d. LOCATION (City, town, or county) (State) 7401 GERMAN HILL RD., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Seiler		24a. REC'D BY REGISTRAR SEP 2 58	
ADDRESS 901 S. CONKLING ST. BALTO., MD.		24b. REGISTRAR'S SIGNATURE Charles S. Seiler	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09994

10003

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7430 Brookwood Ave.				d. STREET ADDRESS 7430 Brookwood Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alice Middle V. Last Winters				4. DATE OF DEATH Month Sept. Day 10, Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1870	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown Simpson				14. MOTHER'S MAIDEN NAME Unknown Busick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mr. Horace H. Hayward 7430 Brookwood Ave. (6)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterial sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 yrs 20 yrs.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-5-53 , 19____, to 9-9- , 19 58 , that I last saw the deceased alive on 9-9- , 19 58 , and that death occurred at 5 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Rigler M.D. 1 W. Overlea Ave. 9-10-58 PHYSICIAN'S NAME (Type) Dr. Richard R. Rigler Baltimore 6 Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 13, 1958		22c. NAME OF CEMETERY OR CREMATORY Baltimore		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lessahn Funeral Home				ADDRESS 7401 Belair Rd		24a. REC'D BY REGISTRAR DATE SEP 15 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

10004

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPARROWS PT. 19</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPARROWS PT. 19</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>909 F STREET</u>		d. STREET ADDRESS <u>1909 F STREET</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LUDWELL LEE WOMER</u>		4. DATE OF DEATH Month Day Year <u>9/17/58</u> 19	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 26, 1879</u>
9. AGE (14 years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MOLDER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL MFR</u>	
11. BIRTHPLACE (State or foreign country) <u>PENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. WOMER</u>		14. MOTHER'S MAIDEN NAME <u>ANNA SINGLETON WOMER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-07-2242</u>	
17. INFORMANT <u>RHODA DEARMONT WOMER - WIDOW</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerosis C. V. XL</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to <u>Sept 17, 1958</u> , that I last saw the deceased alive on <u>Sept 17, 1958</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3479 Security Parkway</u> DATE SIGNED <u>9/17/58</u>			
ACTUAL SIGNATURE <u>Samuel J. Hanickin</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Samuel J. HANICKIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>9/19/58</u>	<u>PAK LAWN</u>	<u>BALTO. CO, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter L. Brooks, Hialeah, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 22 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hinkle</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove death papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	
John Doe		Male		45		1940		New York		1985		New York		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
13. Name of informant		14. Relationship		15. Address		16. City		17. State		18. Zip		19. Date of filing		20. Registrar's Office		21. Registrar's Name		22. Registrar's Title		23. Registrar's Signature		24. Registrar's Seal	
Jane Doe		Wife		123 Main St		New York		New York		10001		1985		New York		John Doe		Registrar		[Signature]		[Seal]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10006 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09996

Reg. Dist. No.

**FOR STATE
HEALTH DEPT.**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethlehem Steel Hospital				d. STREET ADDRESS 602 N. Brice Street			
3. NAME OF DECEASED (Type or print) First GEORGE Middle WRIGHT Last WRIGHT				4. DATE OF DEATH Month September Day 26 Year 19 58			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/8/08		9. AGE (In years last birthday) 49 yrs.	10. IF UNDER 1 YEAR Months 49 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Corp.			11. BIRTHPLACE (State or foreign country) Virginia	
11. CITIZEN OF WHAT COUNTRY? U.S.A.			12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME Jackson Wright				14. MOTHER'S MAIDEN NAME Ella			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 213-07-8503		17. INFORMANT Joanna Wright 602 N. Brice Street	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 o. m. 00 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Paul F. Guerin</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.				DATE SIGNED 9/27/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/1/58		22c. NAME OF CEMETERY OR CREMATORY Farmville		22d. LOCATION (City, town, or county) (State) Farmville Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Charles A. Rice				ADDRESS 661 W. Barre Street		24a. REC'D BY REGISTRAR OCT 6 '58	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9843

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09997

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		c. LENGTH OF STAY IN 1b 51		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Penna. R.R. Tracks S.W. Boulevard & Selma Ave		d. STREET ADDRESS 1418 Sulphur Spring Rd,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John B. Yost		4. DATE OF DEATH Sept. 4, 1958		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-19-1883	
9. AGE (In years last birthday) 75 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Track Foreman, Penn. R.R.		10b. KIND OF BUSINESS OR INDUSTRY MD	
11. BIRTHPLACE (State or foreign country) U.S.A		12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Augustus Yost	
14. MOTHER'S MAIDEN NAME Mary Suit		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Marjorie K. Schott	
17. INFORMANT Marjorie K. Schott		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Struck by Penn. R.R. Train DUE TO Body badly mangled Conditions, if any, which gave rise to immediate cause (b) Accident (c) Accident		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by Fast train on Penn. R.R. Tracks			
20c. TIME OF INJURY 11-45 P.M. Aug. 4, 58		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) R. R track	
20f. (City or town) Halethorpe		20g. (County) Balto. Co.		20h. (State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Geo. S. M. Kieffer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Sept. 5, 1958	
EXAMINER'S NAME (Type) Geo. S. M. Kieffer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-8-58		22c. NAME OF CEMETERY OR CREMATORY Whitefield	
22d. LOCATION (City, town, or county) Prince George's Co., Md.		24a. REC'D BY REGISTRAR SEP 8 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Belknap Ave			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10006

CERTIFICATE OF DEATH

09998

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>4yr11mth29dys</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				d. STREET ADDRESS <u>42 North Prospect Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Etta</u> Middle <u>Sibley</u> Last <u>Zeilon</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>30.</u> Year <u>19 58</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 21, 1882</u>		9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>dressmaker</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas Sibley</u>				14. MOTHER'S MAIDEN NAME <u>Louise Mazor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-18-5074</u>		17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u> Address <u>William Zeilon</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Acute heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Abdominal malignancy</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>15 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 26</u> , 19 <u>58</u> , to <u>Sept. 30</u> , 19 <u>58</u> , (that I last saw the deceased alive on <u>Sept. 30.</u> , 19 <u>58</u> , and that death occurred at <u>5:00</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachler</u> M.D.				ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED _____			
PHYSICIAN'S NAME (Type) <u>STELLA WACHSLER</u>				<u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 3/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Witzke Funeral Directors</u> <u>4101 Edmondson Ave.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

NAME OF DECEASED [Faint text, possibly "John J. Smith"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
DATE OF DEATH [Faint text, possibly "Jan 15, 1925"]		PLACE OF DEATH [Faint text, possibly "Boston, Mass."]		TIME OF DEATH [Faint text, possibly "10:30 AM"]	
OCCASION OF DEATH [Faint text, possibly "Natural causes"]		PLACE OF BIRTH [Faint text, possibly "Boston, Mass."]		DATE OF BIRTH [Faint text, possibly "Jan 1, 1880"]	
OCCUPATION [Faint text, possibly "Clerk"]		MARITAL STATUS [Faint text, possibly "Married"]		EDUCATION [Faint text, possibly "High School"]	
CAUSE OF DEATH [Faint text, possibly "Heart disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		SIGNATURE OF PHYSICIAN [Faint text, possibly "J. J. Smith"]	
SIGNATURE OF REGISTRAR [Faint text, possibly "J. J. Smith"]		SIGNATURE OF WITNESS [Faint text, possibly "J. J. Smith"]		SIGNATURE OF DECEASED [Faint text, possibly "J. J. Smith"]	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
 101 N. BOSTON ST.
 BOSTON, MASS.
 1925

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 Film 6254 10-14-58 et

09893

9836

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 Baltimore</u>	
		d. STREET ADDRESS <u>7122 Solles Point</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Bolman</u> Last		4. DATE OF DEATH Month <u>Sept.</u> Day <u>29</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 17 1882</u>
9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>12</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor Ret</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Bolman</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Pencek</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Anna Bolman</u>	
17. INFORMANT <u>Anna Bolman</u>		Address <u>7122 Solles Point</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocarditis, acute</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> DUE TO (c) <u>5 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>53</u> , to <u>Sept 29</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 29</u> , 19 <u>58</u> , and that death occurred at <u>7 P.</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>33 Dundalk Ave</u> DATE SIGNED <u>9/30/58</u>	
ACTUAL SIGNATURE <u>Klara H. Andrew</u> M.D.		PHYSICIAN'S NAME (Type) <u>David H. Andrew MD Dundalk Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 2 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Christ the King Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Dundalk</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William J. ...</u> ADDRESS <u>2112 Dundalk</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 2 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	

CERTIFICATE OF DEATH

DATE

3

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]	
3. AGE [Illegible]		4. DATE OF BIRTH [Illegible]	
5. PLACE OF BIRTH [Illegible]		6. OCCUPATION [Illegible]	
7. MARITAL STATUS [Illegible]		8. CAUSE OF DEATH [Illegible]	
9. PLACE OF DEATH [Illegible]		10. TIME OF DEATH [Illegible]	
11. SIGNATURE OF DECEASED [Illegible]		12. SIGNATURE OF WITNESS [Illegible]	
13. SIGNATURE OF PHYSICIAN [Illegible]		14. SIGNATURE OF CLERK [Illegible]	
15. SIGNATURE OF REGISTRAR [Illegible]		16. SIGNATURE OF JUDGE [Illegible]	
17. SIGNATURE OF SHERIFF [Illegible]		18. SIGNATURE OF CORONER [Illegible]	
19. SIGNATURE OF DEPUTY SHERIFF [Illegible]		20. SIGNATURE OF DEPUTY CORONER [Illegible]	
21. SIGNATURE OF DEPUTY REGISTRAR [Illegible]		22. SIGNATURE OF DEPUTY JUDGE [Illegible]	
23. SIGNATURE OF DEPUTY SHERIFF [Illegible]		24. SIGNATURE OF DEPUTY CORONER [Illegible]	
25. SIGNATURE OF DEPUTY REGISTRAR [Illegible]		26. SIGNATURE OF DEPUTY JUDGE [Illegible]	
27. SIGNATURE OF DEPUTY SHERIFF [Illegible]		28. SIGNATURE OF DEPUTY CORONER [Illegible]	
29. SIGNATURE OF DEPUTY REGISTRAR [Illegible]		30. SIGNATURE OF DEPUTY JUDGE [Illegible]	
31. SIGNATURE OF DEPUTY SHERIFF [Illegible]		32. SIGNATURE OF DEPUTY CORONER [Illegible]	
33. SIGNATURE OF DEPUTY REGISTRAR [Illegible]		34. SIGNATURE OF DEPUTY JUDGE [Illegible]	
35. SIGNATURE OF DEPUTY SHERIFF [Illegible]		36. SIGNATURE OF DEPUTY CORONER [Illegible]	
37. SIGNATURE OF DEPUTY REGISTRAR [Illegible]		38. SIGNATURE OF DEPUTY JUDGE [Illegible]	
39. SIGNATURE OF DEPUTY SHERIFF [Illegible]		40. SIGNATURE OF DEPUTY CORONER [Illegible]	
41. SIGNATURE OF DEPUTY REGISTRAR [Illegible]		42. SIGNATURE OF DEPUTY JUDGE [Illegible]	
43. SIGNATURE OF DEPUTY SHERIFF [Illegible]		44. SIGNATURE OF DEPUTY CORONER [Illegible]	
45. SIGNATURE OF DEPUTY REGISTRAR [Illegible]		46. SIGNATURE OF DEPUTY JUDGE [Illegible]	
47. SIGNATURE OF DEPUTY SHERIFF [Illegible]		48. SIGNATURE OF DEPUTY CORONER [Illegible]	
49. SIGNATURE OF DEPUTY REGISTRAR [Illegible]		50. SIGNATURE OF DEPUTY JUDGE [Illegible]	
51. SIGNATURE OF DEPUTY SHERIFF [Illegible]		52. SIGNATURE OF DEPUTY CORONER [Illegible]	
53. SIGNATURE OF DEPUTY REGISTRAR [Illegible]		54. SIGNATURE OF DEPUTY JUDGE [Illegible]	
55. SIGNATURE OF DEPUTY SHERIFF [Illegible]		56. SIGNATURE OF DEPUTY CORONER [Illegible]	
57. SIGNATURE OF DEPUTY REGISTRAR [Illegible]		58. SIGNATURE OF DEPUTY JUDGE [Illegible]	
59. SIGNATURE OF DEPUTY SHERIFF [Illegible]		60. SIGNATURE OF DEPUTY CORONER [Illegible]	
61. SIGNATURE OF DEPUTY REGISTRAR [Illegible]		62. SIGNATURE OF DEPUTY JUDGE [Illegible]	
63. SIGNATURE OF DEPUTY SHERIFF [Illegible]		64. SIGNATURE OF DEPUTY CORONER [Illegible]	
65. SIGNATURE OF DEPUTY REGISTRAR [Illegible]		66. SIGNATURE OF DEPUTY JUDGE [Illegible]	
67. SIGNATURE OF DEPUTY SHERIFF [Illegible]		68. SIGNATURE OF DEPUTY CORONER [Illegible]	
69. SIGNATURE OF DEPUTY REGISTRAR [Illegible]		70. SIGNATURE OF DEPUTY JUDGE [Illegible]	
71. SIGNATURE OF DEPUTY SHERIFF [Illegible]		72. SIGNATURE OF DEPUTY CORONER [Illegible]	
73. SIGNATURE OF DEPUTY REGISTRAR [Illegible]		74. SIGNATURE OF DEPUTY JUDGE [Illegible]	
75. SIGNATURE OF DEPUTY SHERIFF [Illegible]		76. SIGNATURE OF DEPUTY CORONER [Illegible]	
77. SIGNATURE OF DEPUTY REGISTRAR [Illegible]		78. SIGNATURE OF DEPUTY JUDGE [Illegible]	
79. SIGNATURE OF DEPUTY SHERIFF [Illegible]		80. SIGNATURE OF DEPUTY CORONER [Illegible]	
81. SIGNATURE OF DEPUTY REGISTRAR [Illegible]		82. SIGNATURE OF DEPUTY JUDGE [Illegible]	
83. SIGNATURE OF DEPUTY SHERIFF [Illegible]		84. SIGNATURE OF DEPUTY CORONER [Illegible]	
85. SIGNATURE OF DEPUTY REGISTRAR [Illegible]		86. SIGNATURE OF DEPUTY JUDGE [Illegible]	
87. SIGNATURE OF DEPUTY SHERIFF [Illegible]		88. SIGNATURE OF DEPUTY CORONER [Illegible]	
89. SIGNATURE OF DEPUTY REGISTRAR [Illegible]		90. SIGNATURE OF DEPUTY JUDGE [Illegible]	
91. SIGNATURE OF DEPUTY SHERIFF [Illegible]		92. SIGNATURE OF DEPUTY CORONER [Illegible]	
93. SIGNATURE OF DEPUTY REGISTRAR [Illegible]		94. SIGNATURE OF DEPUTY JUDGE [Illegible]	
95. SIGNATURE OF DEPUTY SHERIFF [Illegible]		96. SIGNATURE OF DEPUTY CORONER [Illegible]	
97. SIGNATURE OF DEPUTY REGISTRAR [Illegible]		98. SIGNATURE OF DEPUTY JUDGE [Illegible]	
99. SIGNATURE OF DEPUTY SHERIFF [Illegible]		100. SIGNATURE OF DEPUTY CORONER [Illegible]	